
HEALTH INSURANCE REFORM AND INTIMATIONS OF CITIZENSHIP

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Illness is the night-side of life, a more onerous citizenship. Everyone who is born holds dual citizenship, in the kingdom of the well and in the kingdom of the sick.

Susan Sontag¹

INTRODUCTION

Sometimes what is implied and inferred can be as important as what is stated. In this Article, I argue that the political debate that preceded the enactment of the Patient Protection and Affordable Care Act (PPACA),² as well as the legal debate that now swirls around the question of its constitutionality, mask a foundational question about national identity. PPACA, of course, does not literally constitute or reconstitute citizenship (although it does require legal residence as the price of admission).³ But it creates the potential for broad public conversation—as has never before occurred in the United States—regarding the question of what the relationship should be between membership in the American community and meaningful access to health care.

At face value, PPACA primarily seeks to make the individual and small-group health insurance markets rational and workable, to fill the enormous gap that has existed in coverage, and to create insurance exchanges to regulate quality and police access.⁴ Upon full implementation, it will achieve nearly universal, but also probably quite uneven, coverage and will perpetuate a deeply fragmented model of social insurance. If one imagines the health care system as a political domain, with the various institutions and subsystems as components, PPACA is less like our Constitution and more like a reinvention of the Articles of Confederation. Under PPACA, health insurance in the United States will remain a federated collection of risk pools, located in workplaces, public systems, and the new exchanges.

¹ SUSAN SONTAG, *ILLNESS AS METAPHOR* 3 (1978).

² Pub. L. No. 111-148, 124 Stat. 119 (2010) (to be codified as amended in scattered sections of 21, 25, 26, 29, and 42 U.S.C.).

³ See PPACA § 1312(f)(3), 42 U.S.C.A. § 18032(f)(3) (West Supp. 1B 2010) (noting that qualified individuals, for the purposes of the Act, are only those who are citizens or aliens lawfully present).

⁴ I do not mean to diminish the importance of PPACA's expansions of Medicare and especially Medicaid. I do not discuss them in this article because they are extensions of existing programs, and I focus here on PPACA's role in the creation of new institutions and norms.

Nonetheless, the debate that has accompanied PPACA's adoption is about something bigger than spending curves, comparative effectiveness, or even medical-loss ratios (not that any of those should be considered trivial). The deep structure of this hyper-technical statute gestures to the existence of a health care universe that, in Habermasian terms, could be its own lifeworld.⁵ For persons with chronic diseases, the health care system truly becomes a world unto itself. For others, it may be more like a foreign country visited for an intense but brief period of time, or perhaps one to which we pay little attention.⁶ Although the internal operations of the health care universe are seldom thought of as political, its power is such that, upon entry, it may bring us life or death, profit or poverty, autonomy or dependency.

In the interface between the health care system and the legal system, multiple legal paradigms are in play. For questions of access to care through insurance, a mixture of contract and social welfare principles dominate, implicating norms of social solidarity as well as the exchange of defined promises and entitlements. As Lawrence Mead has noted, social welfare programs that incorporate both benefits and reciprocal obligations provide individuals with an "operational definition of citizenship."⁷

PPACA creates a new social welfare and insurance program that redesigns access to health care. Its precise impact on the social meanings associated with individual health and the health of the nation is difficult to predict, but it almost certainly will be powerful. A discourse on belonging, rights and obligations—a discourse on citizenship—is likely to evolve as the effects of the reform take hold. If that occurs, the question will not be *whether* PPACA will provide some operational definition of what we understand to be the scope of social citizenship, but *how* it does so; not *if* there will be some ethic of rights and obligations that will develop around the new law, but *what* the content of that ethic will be. As in real, rather than metaphorical, citizenship, belonging in the reformed health care system will be defined in part by those who are not permitted to belong, and rights will be defined in part by their circumscription. The determination of the

⁵ Habermas used the term "lifeworld" to describe major domains of social and individual life, such as the market or the family. See JÜRGEN HABERMAS, BETWEEN FACTS AND NORMS: CONTRIBUTIONS TO A DISCOURSE THEORY OF LAW AND DEMOCRACY 353-54 (William Rehg trans., 1996).

⁶ Thanks to Bill Sage for suggesting these analogies.

⁷ LAWRENCE M. MEAD, BEYOND ENTITLEMENT: THE SOCIAL OBLIGATIONS OF CITIZENSHIP 249 (1986) (emphasis omitted).

validity of the individual mandate, which is occurring in the current litigation challenging the constitutionality of PPACA,⁸ will profoundly shape the nature of its ethic of obligation.

The debates about PPACA illustrate that constitutional concepts are intertwined with narrative understandings of government authority and individual rights and duties. The trope of the “living Constitution,” for example, began with Franklin Roosevelt, who asserted that we have a “living Constitution” as part of his argument that the Depression necessitated a more capacious scope for executive branch authority.⁹ More recently, the phrase has figured prominently in debates over originalism and has been invoked as an interpretive premise for justifying heightened judicial review of laws curbing individual rights.¹⁰ PPACA may usher in yet another dimension of a “living Constitution”: not as a more expansive understanding of government power or of individual rights, but of our shared obligations to one another.

This Article anticipates how the new health governance structures that PPACA creates may reshape the social meanings, in addition to the finances and mechanics, of the American health system. I develop a concept of “citizenship practices” to describe the components associated with the relationship between the individual and the collective. I argue for using citizenship practices as a substitute for the overused metaphor of citizenship and as a way of capturing the dynamic of belonging, rights, and obligations. This dynamic exists in multiple social and political locations beyond the terms of the legal status of an individual with a particular sovereign state, and thus the frame of citizen-

⁸ See *infra* note 98 and accompanying text.

⁹ See JEFF SHESOL, SUPREME POWER 304, 458-59 (2010) (arguing that President Roosevelt strongly believed that the Justices’ belief in a “living Constitution” was necessary for his ambitious social programs to survive).

¹⁰ The phrase “living Constitution” has been used with distaste by some—and admiration by others—to describe rights-enhancing models of constitutional interpretation. Compare Robert H. Bork, *Neutral Principles and Some First Amendment Problems*, 47 IND. L.J. 1, 1 (1971) (calling “deplorable” the fact that “the nature of the Constitution will change, often quite dramatically, as the personnel of the Supreme Court changes”), and William H. Rehnquist, *The Notion of a Living Constitution*, 54 TEX. L. REV. 693, 706 (1976) (describing a view of a “living Constitution” that would allow “appointed federal judges to impose . . . a rule of conduct that the popular elected branches of governance would not have enacted” as “genuinely corrosive of the fundamental values of our democratic society”), with Adam Winkler, *A Revolution Too Soon: Woman Suffragists and the “Living Constitution,”* 76 N.Y.U. L. REV. 1456, 1523 (2001) (noting that woman suffragists advanced the concept of a living Constitution by looking behind the text and amplifying principles embedded within the document as “restorative of the commitments of American democracy and mandated by the demands of reason”).

ship practices offers a better conceptual tool for understanding the social meaning of new patterns of behavior and belief.

In analyzing citizenship practices related to PPACA, I address how the process by which PPACA creates new institutions will shape the actions of individuals interacting with the health system, including their participation in various, usually localized institutions of governance. These new regularized practices have the potential to lead to new discourses and understandings about the interrelationship between individualism and collectivity, and about the public and private dimensions of the health system. The concept of citizenship practices is intended to capture both the new activities and the new consciousness.

Of greatest importance to this emerging discourse is the individual mandate portion of PPACA.¹¹ Under the Act's "minimum essential coverage" provision, all but a small number of Americans must either purchase health insurance or pay a penalty.¹² The individual mandate requires most U.S. residents to obtain health insurance for themselves and their dependents no later than 2014; those who do not comply will be subject to a tax penalty.¹³ Enrollment in most private sector health plans will satisfy the mandate; acceptable plans include employer-sponsored policies,¹⁴ policies sold on the individual market, existing

¹¹ PPACA § 1501(b), 26 U.S.C.A. § 5000A (West Supp. 1A 2010).

¹² *Id.* The mandate applies to residents lawfully in the United States, except those who are incarcerated, who file a religious conscience objection, or who participate in a preexisting health care sharing ministry. *Id.*, 26 U.S.C.A. § 5000A(d). In addition, designated exemptions are made for American Indians, individuals lacking insurance for three months or less, or those eligible for a "hardship exemption" based on low income. *Id.*, 26 U.S.C.A. § 5000A(e). Individuals eligible for a hardship exemption include those for whom the cost of the lowest available plan after applicable subsidies are applied exceeds eight percent of income, those with income less than the federal income tax filing threshold, or those otherwise defined by the Secretary to have "suffered a hardship with respect to the capability to obtain coverage under a qualified health plan." *Id.*

¹³ *Id.* 26 U.S.C.A. § 5000A(b). The tax penalty will be the greater of a flat tax (starting at \$95 in 2014, increasing to \$695 by 2016, and thereafter subject to cost-of-living adjustments) or an income-based tax (starting at 1% of income in 2014, increasing to 2.5% by 2016). *Id.* § 10106(b)(1), 26 U.S.C.A. § 5000A(c)(2)(B); Health Care and Education Reconciliation Act of 2010 § 1002, 26 U.S.C.A. § 5000A(c)(3)(d). A reduced (one-half) penalty will apply for failure to insure children. PPACA § 1501(b), 26 U.S.C.A. § 5000A(c)(3)(C). By 2016, penalties will be capped at the greater of 2.5% of income or three times the individual penalty, and may not exceed the national average premium cost of the least expensive plan sold on the applicable exchange. *Id.* § 10106(b)(1), 26 U.S.C.A. § 5000A(c)(2)(B).

¹⁴ PPACA's "pay or play" provision creates a mandate for large employers, requiring them to either offer employees a minimum coverage option (play), cover the cost sharing subsidy, or provide a tax credit for employees to purchase coverage on an exchange (pay). *Id.* § 1513(a), 26 U.S.C.A. § 4980H.

health plans grandfathered into the new regulations, or any other plan or policy providing "minimum essential coverage" as defined by the Secretary of Health and Human Services.¹⁵ Those who enroll in public plans such as Medicaid or Medicare will also be in compliance.¹⁶

Part I of this article provides a framework for analyzing the relationships between citizenship concepts and social insurance systems such as PPACA. I describe the inexactitude of both theory and law as to the obligations of citizenship in the United States and discuss the ways in which a tradition of consumer citizens has filled in some of the gaps in the social meaning of citizenship. I also examine the role of social insurance programs, specifically assessing the Social Security system to demonstrate how a concrete model of social citizenship can develop.

Part II turns to the specific example of PPACA and examines both the structural and symbolic roles played by the individual mandate. I argue that the current litigation over the constitutionality of PPACA has generated a contest of signification between the competing values associated with economic liberty and the social compact. Thus, while the Supreme Court will decide whether the individual mandate is valid based on its interpretation of congressional power under Article I, the popular understanding of this debate is much more grounded in a contest of meaning over how much the individual can be forced to participate in a social insurance system.

Part III elaborates on the concept of citizenship practices and its usefulness in analyzing structures for participation in American society. I explain the concept of citizenship practices as referring to regularized behaviors and interactions with a system of governance and a coherent (although not necessarily universal) set of beliefs about the meaning of those behaviors. I then examine specific and concrete governance issues that must be addressed in the implementation phases of PPACA and argue that the resolution of those questions could enhance or inhibit an understanding of PPACA as a new form of social citizenship in the United States.

I. SOCIAL INSURANCE AND THE EPISTEMOLOGY OF CITIZENSHIP

Social insurance programs operate, in many ways, as instruments of governance. They channel, incentivize, and penalize behaviors; establish systems of rights and requirements; distribute risks and provide a promise of collective security against shared risk; and define mem-

¹⁵ *Id.* § 1501(b), 26 U.S.C.A. § 5000A(f).

¹⁶ *Id.*

bership in a collective undertaking.¹⁷ In social insurance, as in structures of government, a tension exists between the goals of collective good and of individual freedom. The identification and pricing of risk, financed and subsidized by public funds, effectively implements redistributive policy decisions. Even private insurance performs critical social functions: Tom Baker has described insurance law principles as a “guide to the social compact,”¹⁸ and Jeffrey Stempel argues that insurance policies function as “social institutions or social instruments . . . often acting as adjunct arms of governance”¹⁹ and as “part of the social policy infrastructure.”²⁰

Pooling risk as a method of achieving security characterizes both social insurance programs and private insurance policies. It is only in the former, however, that the shared understandings of such systems create a sense of social solidarity. Social insurance exists in an epistemological space where notions of common good intersect with beliefs about individual obligation. As a result, social insurance aligns with the conceptual trilogy of belonging, rights, and duties that is essential to any meaning of citizenship.²¹

This Part examines how the concepts and functioning of social insurance systems relate to understandings of citizenship. The dominant theme in citizenship theory has been an articulation of rights. My focus is different: I look more deeply into the *duties* associated with the citizen role and into the question of how program-design structure can shape individual participation in governance activities. I analyze how these components of citizenship as a social role—rather than of citizenship as a formal legal status—operate in social insurance systems.

In doing so, I apply insights from non-legal scholarship about the interrelationship of economic-political notions of citizenship and the socio-political role of consumers. What political scientists have labeled as a right of participation in the private sector has historically taken the form of consumer movements or, when limited to the

¹⁷ See generally RICHARD V. ERICSON ET AL., *INSURANCE AS GOVERNANCE* 35-46 (2003) (describing the collective sharing of risk as “the hallmark of citizenship in strong social democracies”).

¹⁸ Tom Baker, *On the Genealogy of Moral Hazard*, 75 TEX. L. REV. 237, 291 (1996).

¹⁹ Jeffrey W. Stempel, *The Insurance Policy as Social Instrument and Social Institution*, 51 WM. & MARY L. REV. 1489, 1495 (2010).

²⁰ *Id.* at 1511.

²¹ See *infra* notes 22-47 and accompanying text. I borrow the term “belonging” from Kenneth Karst and intend it to encompass norms of participation and social solidarity. See generally KENNETH KARST, *BELONGING TO AMERICA: EQUAL CITIZENSHIP AND THE CONSTITUTION* (1989).

workplace, of organized labor. I analyze how PPACA offers the potential for testing whether individuals will act as “consumer citizens” in the new health insurance system.

Finally, to establish a rough set of benchmarks for assessing the likely impact of PPACA on understandings of citizenship, I conclude this Part with a discussion of Social Security.

A. *The Obligations of Citizenship*

Citizenship-related scholarship has blossomed into an academic cottage industry in recent years,²² but the literature has incorporated health care only minimally into the various categories and functions described by the leading theorists. Modern citizenship theory began with the work of T. H. Marshall, who, writing in the late 1940s against the background of a new British national health system, classified health care as a social right rather than a political or civil right.²³ Marshall treated health care as he did education, arguing that both were essential to dignitary rights and “equality of status.”²⁴

Marshall’s tripartite typology, with its social justice orientation and focus on the relationship between citizenship and social inequality, addressed only the nature of the rights that comprise citizenship.²⁵ Two moves by later scholars of citizenship theory are particularly relevant to the project of understanding how American social insurance programs—including PPACA’s new model—can be analyzed in terms of citizenship. First is the work of scholars who have attempted to recuperate the centrality of obligations as part of the social meaning of citizenship. Second is the addition of an independent right of participation to Marshall’s model.

²² See MARGARET R. SOMERS, GENEALOGIES OF CITIZENSHIP 12-14 (2008) (“Since being awakened from a long dormancy at the end of the twentieth century, studies of citizenship have been making up for lost time at a breathtaking pace.”). For recent additions to the growing field of citizen-related scholarship see, for example, LINDA BOSNIAK, THE CITIZEN AND THE ALIEN (2008); THOMAS JANOSKI, CITIZENSHIP AND CIVIL SOCIETY (1998).

²³ See T.H. MARSHALL, CITIZENSHIP AND SOCIAL CLASS 54 (1950) (describing health care as a means of increasing general social welfare and providing social rights).

²⁴ *Id.* at 56 (arguing that provision of social services is not designed to equalize incomes, but rather to equalize status via “class fusion” when all members of society share a “common experience”).

²⁵ Marshall only briefly discussed concomitant obligations of citizenship. See *id.* at 60-62 (giving examples of subordination of individual rights to collective need in housing and education).

The dominant American tradition of liberal rights has long existed in a dialectical relationship with a tradition of communitarian relationships and obligations.²⁶ The concept of citizenship as a reciprocal relationship dates from the liberal tradition that fueled the American Revolution.²⁷ In the same vein, Kenneth Karst's work on the equal-dignity understanding of citizenship presupposes "two related and overlapping values: participation and responsibility To be a citizen is not merely to be a consumer of rights, but to be responsible to other members of the community."²⁸ Despite the conventional pairing of rights and duties, there has been significantly less elaboration of the responsibility branch than of the rights branch, either in political theory²⁹ or in constitutional law or scholarship. A robust debate about obligations of citizenship has emerged, however, in the legal challenges to PPACA.

The law on citizen duties that does exist is structured in concentric circles, moving outward from those obligations linked to constitutional text to those that are at most implicit. Beginning at the core, the Supreme Court has upheld congressional authority under Article I's enumerated powers to compel citizens to render military service³⁰ and to file income tax returns and pay the appropriate taxes.³¹

²⁶ See, e.g., MICHAEL SANDEL, *DEMOCRACY'S DISCONTENT: AMERICA IN SEARCH OF A PUBLIC PHILOSOPHY* 201-49 (1996) (discussing the tension between the voluntarist conception of freedom and political control).

²⁷ See LINDA K. KERBER, *NO CONSTITUTIONAL RIGHT TO BE LADIES: WOMEN AND THE OBLIGATIONS OF CITIZENSHIP* 8-9 (1998) (describing various schools of thought during the Revolutionary period grounded in the belief that individuals assumed obligations to the state when accepting citizenship and that the state assumed reciprocal obligations); Linda K. Kerber, *The Meanings of Citizenship*, 84 J. AM. HIST. 833, 833-36 (1997) (asserting that the founding generation "constructed a new and reciprocal relationship between state and citizen").

²⁸ Kenneth L. Karst, *Foreword: Equal Citizenship Under the Fourteenth Amendment*, 91 HARV. L. REV. 1, 8-9 (1977).

²⁹ See JANOSKI, *supra* note 22, at 53 (stating that "citizenship theories . . . have tended to ignore duties and obligations"); *id.* at 219 (describing obligations as the "theoretical stepchild" of citizenship theory). Although Janoski criticized the tendency of theorists to overlook the obligations aspect of citizenship, his own taxonomy of citizens' obligations is fairly shallow, concentrating on the individual's duty to provide financial support (presumably by paying taxes). *Id.* at 53-56.

³⁰ See, e.g., *Selective Draft Law Cases*, 245 U.S. 366, 387-88 (1918) (stating that attacks on the constitutionality of a selective draft law were flawed, as compulsory service is sanctioned by the text of the Constitution and grounded in historical practice).

³¹ See, e.g., *Brushaber v. Union Pac. R.R.*, 240 U.S. 1, 17-18 (1916) (finding that the Sixteenth Amendment's income tax provisions are compatible with the unquestioned constitutional authority to levy income taxes).

The second concentric circle of citizenship duties includes those that one can reasonably infer from constitutional text. For example, the Supreme Court has ruled that enacting a statute that requires individuals to appear and testify in court upon service of a subpoena falls within Congress's powers.³² Even for this noncontroversial proposition, the Court sought constitutional authority from multiple sources: historical tradition dating to Elizabethan England, references in the Fifth and Sixth Amendments to the rights of the accused to certain incidents of trial, and historical understandings of the individual's duty toward the common good.³³ Similarly, repeated references in the Constitution to juries³⁴ implicitly support the conclusion that requiring jury service is a concomitant necessary and proper exercise of Congressional power, even without the explicit constitutional mention of such service.

The third and outermost circle of citizenship duties encompasses the broad discretion recognized under the state police powers doctrine.³⁵ Where a state's police powers are implicated, the Court has invoked communitarian reasoning and rejected claims that an individual's constitutionally protected liberty was violated. For example, in *Butler v. Perry*, the Court relied on "ancient usage and the unanimity of judicial opinion" to reject a Thirteenth Amendment challenge to a state law requiring every able-bodied adult male to contribute physical

³² See, e.g., *Blair v. United States*, 250 U.S. 273, 281-82 (1919) (finding that personal obligations must be put aside at times in order to perform one's public duties, such as responding to a subpoena).

³³ See *Blair*, 250 U.S. at 281. On the final point, the Court elaborated that

the giving of testimony and the attendance upon court or grand jury in order to testify are public duties which every person within the jurisdiction of the Government is bound to perform upon being properly summoned The personal sacrifice involved is a part of the necessary contribution of the individual to the welfare of the public.

Id.

³⁴ See U.S. CONST. art. III, § 2 ("The Trial of all Crimes . . . shall be by Jury . . ."); *id.* amend. VI (granting the accused the right to a trial "by an impartial jury"); *id.* amend. VII (granting the right to a jury trial at common law).

³⁵ For example, in the mid-nineteenth century, the Wisconsin Supreme Court declared,

There are very many instances in which the citizen is required to perform personal service, or render aid to his government, without other compensation than that of his participation in the general good, and his enjoyment of the general security and advantage which result from common acquiescence in such obligations on the part of all the citizens alike, and which is essential to the existence and safety of society.

West v. State, 1 Wis. 209, 234 (1853).

labor to the maintenance of public roads.³⁶ Citing Blackstone's *Commentaries*, which in turn cites Roman law, the Court justified the affirmative duty as a contemporary extrapolation from the first of the *tri-noda necessitas*, namely, repair of bridges, construction of fortifications, and service in the militia.³⁷ Because each community was understood to have a duty to keep thoroughfares within its boundaries in good repair, the obligation of each member of the community to provide labor without compensation to maintain roads was "part of the duty which he owes to the public."³⁸

A strand of case law regarding citizenship-linked duties also exists in public-schooling cases. Courts have upheld truancy laws that punished parents who did not send their children to school on the understanding that public schools were "not so much a right granted to the pupils as a duty imposed upon them for the public good"³⁹ and a "guard against the dangers of 'incompetent citizenship.'"⁴⁰ The concept of education as an appropriate—and indeed enforceable—obligation of citizenship has endured.⁴¹

Beyond this handful of loosely related examples, however, there is considerable muddiness about precisely which obligations are understood to constitute duties of citizenship or what unifying rationale they share. The parties challenging the constitutionality of PPACA have used this lack of clarity to argue for the narrowest understanding of citizenship norms. The word "draft" recurs in the debates over the individual mandate,⁴² for example, and is used to delineate the sharp contrast that conservatives see between PPACA's individual mandate

³⁶ 240 U.S. 328, 330 (1916).

³⁷ *Id.* at 330-31 (citing 1 WILLIAM BLACKSTONE, COMMENTARIES *357).

³⁸ *Id.* at 330.

³⁹ *Fogg v. Bd. of Educ.*, 82 A. 173, 175 (N.H. 1912).

⁴⁰ *Id.*; see also *State v. Hoyt*, 146 A. 170, 171 (N.H. 1929) (relying on *Fogg* for the proposition that requiring children to attend school betters society as a whole).

⁴¹ See, e.g., *Wisconsin v. Yoder*, 406 U.S. 205, 221 (1972) (referring to education as a "general obligation of citizenship"); *Robinson v. Cahill*, 303 A.2d 273, 297 (N.J. 1973) (finding that a system of school financing leading to disparate funding across schools violated the state's obligation to provide an adequate public school system).

⁴² For example, the Virginia Attorney General Kenneth Cuccinelli, a plaintiff in one of the challenges, argued, "This lawsuit is not about health care, it's about our freedom The government cannot draft an unwilling citizen into commerce just so it can regulate him under the Commerce Clause." David M. Drucker, *Virginia Judge Allows Health Care Challenge to Proceed*, ROLL CALL (Aug. 2, 2010, 1:40 PM), <http://www.rollcall.com/news/48911-1.html>; see also Matt Sissel, *Health-Care Reform: Why I'm Suing to Get Back My Freedom*, CHRISTIAN SCI. MONITOR, Sept. 13, 2010, available at 2010 WLNR 18185542 ("I object to being conscripted into a federal health-care program . . .").

and those demands, such as Selective Service, that they *do* consider to be indisputable obligations of citizenship. As the Cato Institute argued in its amicus brief in the Virginia case, "To be sure, there are exceptional situations in which the federal government may mandate individual activity . . . [for example, the draft, jury duty, and payment of income tax]. But these duties go to the heart of American citizenship."⁴³ Similarly, three former Attorneys General of the United States argued in the same case that "the broad police power of the States did . . . include some authority to require affirmative action—but the duty was of the citizen to the state and was rooted in tradition."⁴⁴ In both instances, the authors of the briefs apparently believed that to state the distinction between the duties of citizenship and the obligation to join a national social insurance system was to prove it.

Whether access to health care (via health insurance) is a *right* has long been the master frame of social justice debates in the realm of health. I would have predicted that the national debates following enactment of a broad health reform law would have focused on the extent of newly created rights. What is remarkable about the discourse that has emerged from the constitutional challenges to PPACA so far is the extent to which its master frame is over the proper scope of the individual's obligations.

B. *Participation Rights and Citizen Consumers*

Traditional approaches to citizenship, such as Marshall's, have engaged only questions of the individual's relationship to the state. The perspective of citizenship as a social role, however, opens up a broader view that can take a more functional approach to citizenship practices. One such function centers on participation, an element not necessarily limited to the state or to purely public institutions.

Thomas Janoski has argued that participation rights form a fourth category, in addition to Marshall's typology, of the incidents of citizenship.⁴⁵ Janoski defines participation rights as "individual and

⁴³ Memorandum of the Cato Inst. et al. as Amici Curiae Supporting Plaintiff's Opposition to Defendant's Motion to Dismiss at 13, Virginia *ex rel.* Cuccinelli v. Sebelius, 728 F. Supp. 2d 768 (E.D. Va. 2010) (No. 10-0188) [hereinafter Memorandum of the Cato Inst. et al.].

⁴⁴ Memorandum of Amici Curiae, Former United States Attorneys General William Barr, et al., in Support of Plaintiff's Motion for Summary Judgment at 17-18, *Cuccinelli*, 728 F. Supp. 2d 768 (No. 10-0188).

⁴⁵ See JANOSKI, *supra* note 22, at 28-33 (arguing that most theorists have failed to recognize participation rights).

group rights to participate in private decision making through some measure of control over markets, organizations, and capital,” with most of his examples focused on workers and unions.⁴⁶

PPACA creates new opportunities for effectuation of a participation right outside government, not in the employment context but in the potential for the role of consumer to overlap with that of citizen. The border between being a citizen and being a consumer is especially porous in the health care system.⁴⁷ A deep public-private dual identity permeates PPACA’s structure, just as it has long been pervasive in the health care system; the individual mandate’s command to purchase insurance products on the private market is one of countless examples of its manifestation. A correlative right of participation should be viewed as reciprocal to the individual’s obligation to purchase insurance.

New scholarship, primarily in history, has sought to recuperate the idea that consumer experiences can enhance the potential for greater involvement in political activities and for strengthening of democratic values. The work of Lizabeth Cohen especially suggests that “citizen” and “consumer” are not necessarily an antithetical, dichotomous, or mutually exclusive pairing in American politics.⁴⁸ Cohen’s work has excavated a progressive “consumer citizen” identity that flowered during the New Deal.⁴⁹

Government officials during the Roosevelt administration sought both to strengthen and to draw strength from national consumer organizations, declaring that a governance role for consumers would “put the market power of the consumer to work politically.”⁵⁰ Presidential speeches validated the right of consumers “to have their inter-

⁴⁶ *Id.* at 32.

⁴⁷ Cf. Nan D. Hunter, *Rights Talk and Patient Subjectivity: The Role of Autonomy, Equality, and Participation Norms*, 45 WAKE FOREST L. REV. 1525, 1545-47 (2010) (“[T]he American health care system is being actively reshaped by the expectations of consumers and consumer-centric financial incentives.” (citations and internal quotation marks omitted)).

⁴⁸ See LIZABETH COHEN, *A CONSUMERS’ REPUBLIC: THE POLITICS OF MASS CONSUMPTION IN POSTWAR AMERICA* 8 (2003) (“[C]itizen and consumer were ever-shifting categories that sometimes overlapped, often were in tension, but always reflected the permeability of the political and economic spheres.”); see also T.H. BREEN, *THE MARKETPLACE OF REVOLUTION: HOW CONSUMER POLITICS SHAPED AMERICAN INDEPENDENCE*, at XV-XVII (2004) (arguing that the consumer experiences of colonists helped facilitate mobilization for the American Revolution).

⁴⁹ See COHEN, *supra* note 48, at 23-37, 66-112 (describing the New Deal’s “growing attentiveness to consumers as a way of . . . protecting . . . the public interest”).

⁵⁰ *Id.* at 8.

ests represented in the formulation of government policy.”⁵¹ Formal bodies for direct consumer representation were established within the National Recovery Administration (NRA), the Office of Price Administration (OPA) (during World War II), the Tennessee Valley Authority, and the Rural Electrification Administration.⁵² Both the NRA and the OPA set up state and local consumer advisory groups as well.⁵³ This focus on active participation built on and expanded the notion of consumer politics developed during the Progressive Era, when reforms were enacted to protect purchasers from tainted products, but consumer representatives did not join decisionmaking bodies.⁵⁴

Cohen argues that the consumer-citizen framework emerged during the 1930s as a politically “acceptable way of promoting the public good” without invoking overtly socialist rhetoric, and as a tactic for melding democratic values with the preservation of capitalism.⁵⁵ Both of these objectives resonate with the political history of PPACA as well. What Tom Baker describes elsewhere in this volume as the trade-off in PPACA between social solidarity and the insurance law precept of fair (i.e., actuarially justified) discrimination⁵⁶ speaks to the same perceived political need to balance themes of collective responsibility with those of individualism that Cohen discerned in the New Deal.

A note of caution is in order. I do not mean to overstate the progressive potential for consumer citizen politics. Access to health care in the United States has long turned on a bargained-for form of “belonging” to what is typically a private market risk pool without any meaningful accompanying rights.⁵⁷ On this view, the political rela-

⁵¹ *Id.* at 30 (internal citations omitted).

⁵² *Id.* at 28-31, 66-67.

⁵³ *Id.* at 66-67.

⁵⁴ *See id.* at 21-23 (describing the efforts to organize consumer advocacy groups and to pass legislation in the early 1900s).

⁵⁵ *Id.* at 23.

⁵⁶ Tom Baker, *Health Insurance, Risk, and Responsibility After the Patient Protection and Affordable Care Act*, 159 U. PA. L. REV. 1577, 1602 (2011) (“[T]he [PPACA] extends the fair share approach to health care financing by bringing more people under the health insurance umbrella. At the same time, the Act extends the nondiscrimination vision of what constitutes a fair share from the large-group market into the individual and small-group market.”).

⁵⁷ Since 1974, the Employee Retirement Insurance Security Act (ERISA), 29 U.S.C. §§ 1001-1461 (2006), has dominated regulation of the biggest chunk of the health insurance market employer-sponsored plans. ERISA does not require employers to offer health benefits, nor does it offer any correlative right of employees to gain access to coverage. Generally, the terms of ERISA have been interpreted to limit liability to plans should employers breach contracts with their employee enrollees. *See, e.g.*, Katherine L. Record, Note, *Wielding the Wand Without Facing the Music: Allowing Utiliza-*

tionship of individuals to the American health care system illustrates what Margaret Somers has described as only a thin form of “contractualized” citizenship.⁵⁸ This kind of link between citizenship and consumer activities points to an understanding of governance as stakeholder pluralism, rather than as a reinforcement of social solidarity norms. Consistent with that concern, the normative values associated with a contract-based understanding of citizenship in the health care system speak less to social solidarity than to the individual’s capacity to identify and purchase coverage that will most closely match her cost and quality preferences.⁵⁹

However, it would also be a mistake to dismiss entirely the potential for mobilization that attends participation in market-oriented activities and practices. The experience of consumer citizenship in the 1930s succeeded in two key respects important for a project linked to progressive values: democratic norms and practices reached federal, state, and local levels of governance, and the resulting institutions went beyond *representation* of consumer interests to the establishment of systems for consumer *participation* in policymaking. Cohen’s work demonstrates that the participatory mechanisms for consumers during the New Deal did not exist simply as rote formalities, but that citizen consumers were genuinely engaged in that effort as well.⁶⁰ This history of broadly diffused engagement suggests that social insurance programs, including PPACA, could produce effective venues for citizenship practices.

tion Review Physicians to Trump Doctors’ Orders, but Protecting Them from the Legal Risk Ordinarily Attached to the Medical Degree, 59 DUKE L.J. 955, 967 (2010) (noting that ERISA allows recovery of benefits denied but not compensatory or punitive damages—a remedies system that was created for breach of pension). ERISA frames the bulk of American health insurance as a voluntaristic auxiliary in a broader free market system. *Id.* It narrowly protects contractual benefits, and has been interpreted to preempt any claim relating to a plan that would collect further damages (e.g., state law claims of negligence, emotional distress, wrongful death, medical malpractice, and bad faith). *Id.* at 968 n.63. Under ERISA, the “citizen” is a utility maximizing rational actor entitled to the protection of a state apparatus for her bargained-for deserts.

⁵⁸ See SOMERS, *supra* note 22, at 2-3, 68-73 (arguing that contractual citizenship creates groups of citizens who are included in the accompanying rights and groups who are excluded).

⁵⁹ It is not surprising, for example, that PPACA itself contains the term “educated health care consumer,” defined as “an individual who is knowledgeable about the health care system, and has background or experience in making informed decisions regarding health, medical, and scientific matters.” PPACA § 10104(d), 42 U.S.C.A. § 18024(e) (West Supp. 1B 2010).

⁶⁰ See COHEN, *supra* note 48, at 29-31, 34.

C. Social Security

When analyzing an American social insurance scheme, the inevitable comparison is to Social Security, which obligates each working individual to pay a dedicated tax to support the program.⁶¹ Although now a universal system, Social Security originated as a poverty-amelioration program, in which Congress silently perpetuated gender, race, and income inequalities.⁶² It was only over time that the Social Security Act “established American social citizenship.”⁶³

Similarly to PPACA, the threshold legal challenge to Social Security focused on the constitutionality of its financing component, which, unlike the individual mandate in PPACA, was clearly structured as a tax.⁶⁴ The Court found the Social Security Act constitutional pursuant to Congress’s taxing power, without having to consider the scope of the Commerce Clause.⁶⁵ Yet the logic of the challenge nonetheless

⁶¹ 42 U.S.C. § 301 (2006). Various taxes enacted under the Federal Insurance Contributions Act finance the Social Security program. 26 U.S.C. § 3101(a) (2006).

⁶² Social Security was originally divided between benefits—framed as earnings from worker contributions—and assistance to the needy. See SUZANNE METTLER, *DIVIDING CITIZENS: GENDER AND FEDERALISM IN NEW DEAL PUBLIC POLICY* 55-59 (1998) (chronicling the evolution of ideas on how to implement the Social Security system). Moreover, the system initially excluded agricultural and domestic workers, thus eliminating coverage for half of the African-American population at that time. See JENNIFER KLEIN, *FOR ALL THESE RIGHTS: BUSINESS, LABOR AND THE SHAPING OF AMERICA’S PUBLIC-PRIVATE WELFARE STATE* 104 (2003) (noting that bifurcating Social Security directly resulted in the exclusion of several groups, including African-Americans).

⁶³ METTLER, *supra* note 62, at 54. In 1939, Congress expanded Social Security to allow benefits greater than the amount that the deceased worker had paid in, thus moving away from a “contributory-contractual principle” to a genuine social insurance model, in which government assumed the employee’s responsibility to his family by providing income security. Brian R. Grossman et al., *One Nation, Interdependent: Exploring the Boundaries of Citizenship in the History of Social Security and Medicare*, in LEAH ROGNE ET AL., *SOCIAL INSURANCE AND SOCIAL JUSTICE: SOCIAL SECURITY, MEDICARE, AND THE CAMPAIGN AGAINST ENTITLEMENTS* 115, 127 (2009).

⁶⁴ Then-Secretary of Labor Frances Perkins credited the clarity of constitutional authority for Social Security to advice she received in 1934 from Chief Justice Harlan Stone: “The taxing power, my dear, the taxing power. You can do anything under the taxing power.” Francis Perkins, Sec’y of Labor, Speech at the Social Security Administration: The Roots of Social Security (Oct. 23, 1962), available at <http://www.ssa.gov/history/perkins5.html>.

⁶⁵ *Helvering v. Davis*, 301 U.S. 619, 640-41 (1937). The Supreme Court left open the question of the constitutionality of the tax on individual employees, limiting its holding to the claims brought by employers. See *id.* at 645 (stating only that the tax on employers was valid). Plaintiffs in the challenges to PPACA accept the Social Security tax as a constitutionally legitimate exercise of congressional taxing power, but argue that *Helvering* provides no support for PPACA because PPACA is financed by a mandate to purchase a private commodity, rather than to pay monies to the government. See, e.g., Memorandum of the Cato Inst. et al., *supra* note 43, at 19 (“Although

parallels the political arguments being made against PPACA, and the Court's reasoning in response implies the kind of civic solidarity justification that could be mounted to defend the new law in non-doctrinal arguments.

In the Social Security case, the First Circuit had ruled the Act unconstitutional as a violation of the Tenth Amendment, on the ground that providing assistance to the elderly and poor was a power reserved to the states and not legitimately within Congressional authority.⁶⁶ Moreover, it found that "a tax imposed to benefit slightly over half of the people over sixty-five years of age and who are the care or burden of the states cannot be said to be imposed for the general welfare of the United States."⁶⁷

Justice Cardozo's opinion for the Supreme Court reasoned that although "Congress may spend money in aid of the 'general welfare[.]' . . . [t]he line must still be drawn between one welfare and another, between particular and general."⁶⁸ The Court rejected a "static" concept of the general welfare: "Needs that were narrow or parochial a century ago may be interwoven in our day with the well-being of the Nation. What is critical or urgent changes with the times."⁶⁹ The Court also found the new system to be an appropriate response to urgent need:

Spreading from State to State, unemployment is an ill not particular but general, which may be checked, if Congress so determines, by the resources of the Nation . . . [Nation-wide harm results regardless of] whether men are thrown out of work because there is no longer work to do or because the disabilities of age make them incapable of doing it. Rescue becomes necessary irrespective of the cause.⁷⁰

These passages in *Helvering* performed significant work in the Social Security debate and are extraordinarily rich for present purposes as well. The Court invokes the norms of reciprocal and collective responsibility—"rescue"—that comprise the ethos of citizenship. Further, Justice Cardozo uses the language of emergency—a "nation-wide

the term 'excise' now covers virtually every internal revenue tax except the income tax, the individual mandate penalty (unlike Social Security) is not a tax on employment or other action—it 'taxes' inaction.").

⁶⁶ *Davis v. Edison Elec. Illuminated Co. of Bos.*, 89 F.2d 393, 395 (1st Cir. 1937), *rev'd sub nom. Helvering v. Davis*, 301 U.S. 619 (1937).

⁶⁷ *Id.* at 395.

⁶⁸ *Helvering*, 301 U.S. at 640 (citing U.S. CONST. art. I, § 8, and *United States v. Butler*, 297 U.S. 1, 65 (1936)).

⁶⁹ *Id.* at 641.

⁷⁰ *Id.*

calamity . . . [s]preading from State to State"⁷¹—to ground the necessity for collective mobilization of the sort associated with self-defense and national security. The opinion frames the threat as one to the nation as a whole, requiring a specifically national response, warning of the hazards of relying on multiple state old-age pension systems, and cautioning that "[o]nly a power that is national can serve the interests of all."⁷²

Today, paying Social Security taxes is rarely questioned as falling outside an American's reasonable expectation of the obligations of citizenship, even though Social Security is certainly not essential to the existence of any government. Yet the program functions as an institution or technology of societal solidarity at a sufficiently deep level that it constitutes part of the social meaning of citizenship.

Indeed, political scientist Angela Campbell, who has studied Social Security extensively, concludes that it has been a major factor in making seniors the "[ü]ber-citizens" of American politics.⁷³ On other political issues, senior engagement is no higher than that of other persons; it is the specific interest in Social Security that has led to a relatively larger political presence for that demographic group.⁷⁴ Campbell credits program design and administration, as well as financial support provided by the benefits, with having created the conditions that have produced this result.⁷⁵ Most impressively, Social Security has produced a phenomenon in which low-income beneficiaries have become more active than high-income seniors on issues specific to Social Security.⁷⁶

Engagement by participants has led, in turn, to modifications that have expanded the scope of the program.⁷⁷ Social Security created an identifiable constituency group that attracted interest-group entrepreneurs and political parties, who in turn mobilized greater levels of engagement by program enrollees, who themselves identified gaps in coverage that require additional political action.⁷⁸ This process effectively transformed the low-income elderly—a socially anonymous and

⁷¹ *Id.*

⁷² *Id.* at 644.

⁷³ ANDREA LOUISE CAMPBELL, *HOW POLICIES MAKE CITIZENS: SENIOR POLITICAL ACTIVISM AND THE AMERICAN WELFARE STATE* 2 (2003).

⁷⁴ *See id.* at 48 ("[S]eniors' general political engagement is not higher than that of nonseniors.").

⁷⁵ *Id.* at 136.

⁷⁶ *Id.* at 39.

⁷⁷ *Id.* at 92.

⁷⁸ *Id.* at 77.

diffuse group—into a political power base that became politically legible as discrete and organized, even while remaining diffuse.⁷⁹

The examples of Social Security and New Deal citizen consumer institutions illustrate the power of law to shape cognition and understanding in situations in which meaning is ambiguous and malleable. Social insurance programs can redefine concrete reality and, in the process, alter popular expectations of what are appropriate attitudes and behaviors.

II. THE INDIVIDUAL MANDATE AS LINCHPIN AND SIGNIFIER

A robust debate about the obligations of citizenship has emerged as part of the political discourse surrounding constitutional challenges to PPACA. In this Part, I describe the structural and symbolic importance of the individual mandate to the overall reform effort and to the citizenship-linked meanings of the legislation. Although the provision creating the individual mandate accounted for much of the resistance to the bill, its proponents insisted on its inclusion as the cornerstone of the legislation because it provided a mechanism to address a dysfunctional insurance market.⁸⁰

On the surface, the litigation over whether it is constitutional to require individuals to purchase health insurance policies concerns the scope of the Commerce and the Necessary and Proper Clauses, as well as the applicability of the taxing power. In the subtext to those arguments are the radically different visions of the meaning of the social obligations of citizenship that are fueling popular understandings and debates over the social meaning of the new law.

A. *Economic Necessity*

In the years leading up to the enactment of PPACA, two economic dynamics dominated the health insurance market: prohibitive cost (with premiums increasing at a faster rate than the rate of growth in income) and decreasing participation (forty-six million uninsured in 2007, with one in four households forgoing necessary medical care

⁷⁹ *Id.* at 112-14.

⁸⁰ See, e.g., Press Release, House Comm. on Ways and Means, Health Reform in the 21st Century: Insurance Market Reforms (Apr. 15, 2009) (quoting Ways and Means Committee Chairman Charles Rangel as saying that “America’s health insurance market is dysfunctional,” evidenced by “the 87 million people who went without health insurance during the past two years and the millions more who have insurance that is increasingly unaffordable or inadequate”).

due to cost).⁸¹ Expanding access to coverage required reforming two profit-boosting strategies that underlay these problems: medical underwriting and discrimination based on preexisting conditions. The mandate was essential to PPACA's structure for tightening regulatory control without abandoning a market-based health insurance system.

Medical underwriting—structuring premiums inversely with health status—created an insurance landscape that made coverage increasingly unaffordable to those most likely to need care. Thus, to expand coverage to the sickest Americans, Congress had to eliminate underwriting and require insurers to adhere to community-rated premiums (e.g., to charge all beneficiaries with the same premium, subject only to age variation).⁸² In doing so, Congress sought not only to increase affordability of coverage, but also to incentivize insurers to design and implement effective cost-containment strategies, thereby controlling growth in national health care expenditures.⁸³

Discrimination based on pre-existing conditions (e.g., denying or rescinding coverage for health conditions pre-dating policy enrollment) had shut off access to insurance for many patients in immediate need of care. To facilitate coverage of high-cost health care services, Congress required insurers to offer guaranteed issue and guaranteed renewal of coverage, and limited insurers' ability to mask unexpected exclusions of coverage in cumbersome contracts.⁸⁴ In addition, Congress required coverage of "essential benefits," and re-

⁸¹ *Id.*

⁸² See *Health Reform in the 21st Century: Insurance Market Reforms: Hearing Before the H. Comm. on Ways and Means*, 111th Cong. 13 (2009) (statement of Uwe E. Reinhardt, Professor, Princeton University) (noting that health care will never be available to "all Americans on equal terms" as long as insurance companies practiced underwriting, and advocating community-rated premiums instead), available at http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_house_hearings&docid=f:52258.pdf.

⁸³ Only one percent of patients account for more than one quarter of health care spending, with five percent accounting for approximately half. Samuel H. Zuvekas & Joel W. Cohen, *Prescription Drugs and the Changing Concentration of Health Care Expenditures*, 26 HEALTH AFF. 249, 251 exhibit 2 (2007). This trend remained consistent even through the managed care movement of the 1990s, suggesting that insurers were not designing effective cost-containment policies that would constrain national medical expenditures. *Id.* at 249-50; see also *The Tri-Committee Draft Proposal for Health Care Reform, Hearing Before the H. Comm. on Educ. and Labor*, 111th Cong. 72 (2009) (statement of Jacob Hacker, Co-Director, Berkeley School of Law Center on Health Economic & Family Security) (explaining how insurance markets compete for the lowest-risk enrollees rather than price or quality of care), available at http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_house_hearings&docid=f:50479.pdf.

⁸⁴ PPACA sec. 1201, §§ 2702-2703, 42 U.S.C.A. §§ 300gg-1 to -2 (West Supp. 1A 2010).

stricted the cost-sharing arrangements that had discouraged individuals from seeking preventive care before becoming ill.⁸⁵

The purpose of prohibiting medical underwriting and discrimination based on preexisting conditions was to open the insurance market to individuals of all health statuses, thereby expanding coverage to many of those in greatest need. Yet requiring insurers to take on high-risk beneficiaries at lower cost—without mandating that healthy individuals join insurance pools—would have killed the private market by simultaneously reducing premium income and increasing expenditures.⁸⁶

State-based reforms had demonstrated this effect. For example, Congress considered the experience of New Jersey's Individual Health Coverage Program of 1993, which required insurers to use guaranteed issue and community-based ratings on the individual market, but did not require uninsured residents to obtain coverage.⁸⁷ Within a decade, the state's insurance market began to flounder, as the proportion of high-risk to low-risk beneficiaries increased.⁸⁸ By failing to require healthy individuals to purchase insurance before they fall ill, and securing affordable rates for people of all health statuses, the law incentivized free riding and prohibited insurers from minimizing adverse selection.⁸⁹ In contrast to the New Jersey experience, health reform in Massachusetts demonstrated the stability that an individual mandate can bring to risk pooling. Within three years of imposing its mandate, Massachusetts experienced an increase in insurance coverage for non-elderly adults from 87.5% to 95%.⁹⁰

⁸⁵ An essential benefits package, to be defined by the Secretary of Health and Human Services, will establish the minimal amount of benefits a plan may offer on the exchange. *Id.* § 1302(b)(1), 42 U.S.C.A. § 18022(b)(1) (West Supp. 1B 2010). In addition, plans sold on the exchange must cover at least sixty percent of health care costs, *id.* § 1302(d)(1), 42 U.S.C.A. § 18022(d)(1), and out-of-pocket expenditures may not exceed \$5,000 for an individual or \$10,000 for a family. *Id.* § 1302(c)(1), 42 U.S.C.A. § 18022(c)(1). Section 1001 of the Act also amends the Public Health Services Act to prohibit cost sharing for evidence-based preventive services. *Id.* § 1001, 42 U.S.C.A. 300gg-13(a) (West Supp. 1A 2010).

⁸⁶ See *Health Reform in the 21st Century*, *supra* note 82, at 13 (statement of Uwe E. Reinhardt) (arguing that the "imposition of *community-rate premiums* and *guaranteed issue* on a market of competing private insurers will inexorably drive that market into extinction").

⁸⁷ See *id.* at 13 n.4 (citing Alan C. Monheit et al., *Community Rating and Sustainable Individual Health Insurance Markets in New Jersey*, 23 HEALTH AFF. 167 (2004)).

⁸⁸ See Monheit et al., *supra* note 87, at 169 (describing a trend of enrollment consistent with "a marketwide adverse-selection death spiral").

⁸⁹ See *id.* (noting that insurers have been forced to retain "potentially adverse health risks").

⁹⁰ SHARON K. LONG & KAREN STOCKLEY, HEALTH REFORM IN MASSACHUSETTS: AN UPDATE AS OF FALL 2009, at iii (2010); see also PPACA § 10106(a), 42 U.S.C.A.

Taking into account the experience of state-based insurance reform, Congress used a mandate to mitigate the effects of eliminating the insurance industry's primary means of maximizing profit.⁹¹ The mandate allows insurers to effectively pool risk: offsetting the cost of insuring high-risk beneficiaries at affordable rates with the profits earned on healthy beneficiaries.⁹² In other words, the mandate eliminates two market failures: free-riding and improper risk analysis.⁹³

Congress also found the mandate important for addressing issues related to employer-sponsored coverage: continuity in coverage and variability in plans. In light of the increase in lateral career movement, Congress concluded that a mandate would incentivize employees to remain covered during the transition between old and new employer plans.⁹⁴ It would also enhance the accessibility of coverage for the self-employed, unemployed, or underemployed, or those working in small businesses that lack risk-pooling capacity.⁹⁵ PPACA creates state-based health insurance exchanges in order to provide a vehicle for obtaining coverage outside of large employer-sponsored or public plans.⁹⁶ Without the mandate, the financial stability of the exchanges might falter under the force of adverse selection. Thus, the primary role of the individual mandate is to stabilize the private health insurance market.⁹⁷

§ 18091(a)(2)(D) (West Supp. 1B 2010) (describing the "Effects on the National Economy and Interstate Commerce" of the individual mandate and stating that "[i]n Massachusetts, a similar requirement has strengthened private employer-based coverage: despite the economic downturn, the number of workers offered employer-based coverage has actually increased.").

⁹¹ See *Health Reform in the 21st Century*, *supra* note 82, at 9, 101-02 (noting that health reform in New Jersey resulted in an unraveling of the insurance market due to the lack of a mandate).

⁹² See *id.* at 107 (testimony of William Vaughan, Senior Policy Analyst, Consumers Union) (noting that a mandate removes the business necessity of imposing limitations the coverage of on pre-existing conditions); *id.* at 118-19 (statement of the American Academy of Actuaries) (noting that with larger risk pools, insurers can charge lower rates).

⁹³ Representative Schwartz discussed the problem of improper risk analysis seen in young adults tending to underestimate the future risk of accumulating medical costs. *Id.* at 106-07 (statement of Rep. Allyson Schwartz, H. Comm. on Ways and Means).

⁹⁴ There is often either a six-month waiting period to enroll in a new employer's plan or an annual thirty to sixty day enrollment window. *Id.* at 103-05.

⁹⁵ See *id.* at 35-37, 40, 94, 110-16 (discussing insurance barriers for those unable to pool risk).

⁹⁶ PPACA § 1311(b), 42 U.S.C.A. § 18031(b) (West Supp. 1B 2010).

⁹⁷ But the individual mandate will not remedy all troubles of adverse selection within the insurance exchanges. See TIMOTHY STOLTZFUS JOST, COMMONWEALTH FUND, HEALTH INSURANCE EXCHANGES AND THE AFFORDABLE CARE ACT: EIGHT DIFFICULT IS-

B. *A Signification Contest Between Economic Liberty
and the Social Compact*

Lawsuits challenging the constitutionality of PPACA have targeted the individual mandate.⁹⁸ The resolution of these claims, almost certainly by the Supreme Court, will turn on whether the requirement to purchase health insurance is an appropriate exercise of Congressional power under either the Commerce Clause or the taxing power. There seems to be little dispute that this precise form of federal mandate—that individuals must purchase certain private goods or pay a penalty—is unprecedented.⁹⁹ The Court's resolution may depend on whether the Justices calibrate their analysis at a greater or lesser level of generality, by deciding whether the PPACA mandate is a reasonable way to regulate a trillion-dollar economic subsystem or whether it is more like an authoritarian command that each individual must buy a health club membership. In my view, for reasons well stated by Mark Hall,¹⁰⁰ there is no basis for the Court to conclude that the Act is unconstitutional.

My focus in this Article is not on the doctrinal analysis of the debate that will be before the Supreme Court but on the underlying social messages and meanings that are implicated in that debate. In cultural terms, the Court will have to decide whether PPACA is about preserving

SUES 9 (2010) (describing how the continued existence of a market outside the exchange will leave open the possibility of adverse selection).

⁹⁸ See *Florida ex rel. Bondi v. U.S. Dep't of Health & Human Servs.*, No. 10-091, 2011 WL 285683 (N.D. Fla. Jan. 31, 2011); *Virginia ex rel. Cuccinelli v. Sebelius*, 728 F. Supp. 2d 768 (E.D. Va. 2010); *New Jersey Physicians, Inc. v. Obama*, No. 10-1489, 2010 WL 5060597 (D.N.J. Dec. 8, 2010); *Liberty Univ. v. Geithner*, No. 10-0015, 2010 WL 4860299 (W.D. Va. Nov. 30, 2010); *U.S. Citizens Ass'n v. Sebelius*, No. 10-1065, 2010 WL 4947043 (N.D. Ohio Nov. 22, 2010); *Shreeve v. Obama*, No. 10-0071, 2010 WL 4628177 (E.D. Tenn. Nov. 4, 2010); *Florida ex rel. McCollum v. U.S. Dept. of Health & Human Servs.*, 716 F. Supp. 2d 1120 (N.D. Fla. 2010); *Thomas More Law Ctr. v. Obama*, 720 F. Supp. 2d 882 (E.D. Mich. 2010). A number of cases were also filed in which no court opinion had been issued as of April 5, 2011. See Amended Complaint, *Bryant v. Holder*, No. 10-0076 (S.D. Miss. Mar. 4, 2011); Complaint, *Coons v. Geithner*, No. 10-1714 (D. Ariz. Aug. 12, 2010); Complaint, *Calvey v. Obama*, No. 10-0353 (W.D. Okla. Aug. 6, 2010); Complaint, *Ass'n of Am. Physicians & Surgeons v. Sebelius*, No. 10-0499 (D.D.C. Mar. 26, 2010).

⁹⁹ See *McCollum*, 716 F. Supp. 2d at 1164 (quoting a 1994 CBO memorandum determining that the individual mandate would be "an unprecedented form of federal action"); see generally JENNIFER STAMAN, CONG. RESEARCH SERV., R40725, *REQUIRING INDIVIDUALS TO OBTAIN HEALTH INSURANCE: A CONSTITUTIONAL ANALYSIS I* (Dec. 16, 2010) (noting that Congress has never required the transfer of money to private parties except in return for a privilege, such as driving cars).

¹⁰⁰ See Mark A. Hall, *Commerce Clause Challenges to Health Care Reform*, 159 U. PA. L. REV. 1825, 1829-30 (2011) (arguing that Congress is permitted to regulate the insurance industry and that the individual mandate is necessary and proper to that permission).

a fiscally and otherwise healthy collectivity—the nation—or about preserving an individually defined bundle of rights. Perhaps subconsciously, the Justices must frame the relationship between government and individual access to the health care system as primarily either about collective governance or about fostering individual self-governance. Fundamentally, the legitimacy of the individual mandate turns on whether the Court will accept that a sacrifice of individual economic liberty is justified by an obligation to contribute to the common good that accompanies membership in the American political community.

The centrality of economic liberty claims to the individual mandate debate is evident from the current litigation, in which individual plaintiffs have described the harm they suffer from the allegedly unconstitutional exercise of power in economic terms. In *Florida ex rel. McCollum v. United States Department of Health and Human Services*, for example, one plaintiff asserted that he had no health insurance nor any intention of purchasing any, and that, further, “he is, and expects to remain, financially able to pay for his own healthcare services if and as needed.”¹⁰¹ In *Thomas More Law Center v. Obama*, the District Court found that the individual plaintiffs had standing because of the present injury of

being compelled to “reorganize their [financial] affairs” Plaintiffs’ decision to forego certain spending today, so that they will have the funds to pay for health insurance when the Individual Mandate takes effect in 2014, are injuries fairly traceable to the Act for the purposes of conferring standing. There is nothing improbable about the contention that the Individual Mandate is causing plaintiffs to feel economic pressure today.¹⁰²

These assertions recall two cases decided by the Supreme Court slightly more than a century ago which also concerned the legitimacy of a health-related mandate grounded in social welfare policy. In *Jacobson v. Massachusetts*, the Court upheld a requirement that every resident of Cambridge, Massachusetts, be vaccinated for smallpox, rejecting the argument that it violated bodily liberty.¹⁰³ Less than two months later, in *Lochner v. New York*, the Court upheld the primacy of economic liberty and the right of contract by invalidating a law that

¹⁰¹ 716 F. Supp. 2d at 1145.

¹⁰² 720 F. Supp. 2d at 888-89.

¹⁰³ See 197 U.S. 11, 12-13, 26-27 (1905) (“[T]he liberty secured by the Constitution . . . does not import an absolute right in each person to be, at all times and in all circumstances, wholly freed from restraint.”).

set a maximum daily number for hours worked, a law that looked like a present-day occupational health and safety regulation.¹⁰⁴

The contemporary controversy over the legitimacy of the individual mandate in PPACA resonates with these two constitutional landmarks, not at the level of doctrine or precedent but in the realm of social meaning. At bottom, both *Jacobson* and *Lochner* concerned how much sacrifice of liberty could be demanded of the individual by the state in the interest of furthering the social compact, specifically in the context of health. In each case, the Court had to determine how direct or necessary the sacrifice of a right was to achieving the common good. In *Jacobson*, the Court framed the justification for coerced vaccination as necessary, literally, for community survival, a linkage that made sense in the context of an epidemic of infectious disease at the turn of the last century:¹⁰⁵ “Upon the principle of self-defense, of paramount necessity, a community has the right to protect itself against an epidemic of disease which threatens the safety of its members.”¹⁰⁶ The Court also described the individual’s duty as part of a social compact with the state:

There are manifold restraints to which every person is necessarily subject for the common good This court has more than once recognized it as a fundamental principle that “persons and property are subjected to all kinds of restraints and burdens in order to secure the general comfort, health, and prosperity of the State; of the perfect right of the legislature to do which no question ever was, or upon acknowledged general principles ever can be made, so far as natural persons are concerned.”¹⁰⁷

By contrast, the same Court in *Lochner* viewed the maximum hours law as an illegitimate ruse used to curtail the dynamics of the labor market:

The act is not, within any fair meaning of the term, a health law, but is an illegal interference with the rights of individuals, both employers and employes [sic], to make contracts regarding labor upon such terms as

¹⁰⁴ See 198 U.S. 45, 61 (1905), *abrogated by* *W. Coast Hotel Co. v. Parrish*, 300 U.S. 379 (1937) (“The Act is not, within any fair meaning of the term, a health law, but is an illegal interference with the rights of individuals . . .”).

¹⁰⁵ See Ctrs. for Disease Control & Prevention, *Impact of Vaccines Universally Recommended for Children—United States, 1900–1998*, 281 JAMA 1482, 1482 (1999) (“At the beginning of the 20th century, infectious diseases were widely prevalent in the United States and exacted an enormous toll on the population. For example, in 1900, 21,064 smallpox cases were reported, and 894 patients died.”).

¹⁰⁶ *Jacobson*, 197 U.S. at 27.

¹⁰⁷ *Id.* at 26 (citations omitted) (quoting *Thorpe v. Rutland & Burlington R.R.*, 27 Vt. 140, 150 (1854)).

they may think best, or which they may agree upon with the other parties to such contracts.¹⁰⁸

The Court's reasoning in both cases, together with the citizenship cases and *Helvering*, demonstrates that as context and historical circumstance shift, so do the formulations of a citizen's duty.

There are, of course, many ways to distinguish these two cases from the PPACA lawsuits. Perhaps the most important difference is that *Jacobson* and *Lochner* involved the invocation of a state's police power,¹⁰⁹ rather than the invocation by Congress of its powers under Article I. And of course, the *Lochner* era has long since ended;¹¹⁰ unless plaintiffs can demonstrate that a noneconomic, fundamental liberty interest is at stake, the United States need only show that PPACA's individual mandate satisfies rational basis review.¹¹¹ With evidence that Congress went to considerable lengths to clarify that the mandate is necessary to the entire statutory scheme, the Michigan court had little difficulty dismissing plaintiffs' substantive due process claims.¹¹² Thus, the doctrinal resolution of the constitutionality of the mandate centers on the Commerce Clause and tax power, augmented by the Necessary and Proper Clause, and not on recognition of an economic liberty interest.

At the level of social meaning, however, PPACA challenges are not about federalism, the Commerce Clause, or taxation. Just as today I would doubt that a person quarantined after arriving on a flight from New York to Los Angeles would much care whether federal or state health authorities ordered the quarantine,¹¹³ I doubt that the final ruling on the constitutionality of the individual mandate will be understood as resolving the question of which *level* of government has the power to force an individual into a community-rating insurance system. Rather, the popular understanding likely will center on the issue

¹⁰⁸ 198 U.S. at 61.

¹⁰⁹ See *Jacobson*, 197 U.S. at 25 ("According to settled principles, the police power of a State must be held to embrace, at least, such reasonable regulations . . . as will protect the public health and the public safety."); *Lochner*, 198 U.S. at 54 (describing the act at issue as an "assumed exercise of [the state's] police power").

¹¹⁰ See, e.g., *Whalen v. Roe*, 429 U.S. 589, 597 (1977) ("The holding in *Lochner* has been implicitly overruled many times."); *Day-Brite Lighting, Inc. v. Missouri*, 342 U.S. 421, 423 (1952) (recognizing the implied overruling of *Lochner's* holding).

¹¹¹ See *Thomas More Law Ctr. v. Obama*, 720 F. Supp. 2d 882, 891-92 (E.D. Mich. 2010) (stating that the court should determine only whether there is a rational basis for the conclusion that the regulated activities substantially affect interstate commerce).

¹¹² *Id.* at 893-95 (explaining Congress's rational basis for passing PPACA).

¹¹³ Federal quarantine authority is limited to situations in which an individual with a communicable disease may cross state lines. See 42 U.S.C. § 264(d) (2006).

of whether persons can be compelled by *any* level of government to participate in a social insurance compact for the common good, or whether, when the rational economic choice of particular individuals would be to go it alone, a requirement to obtain health insurance would amount to what the *Lochner* court called “meddlesome interference[] with the rights of the individual.”¹¹⁴

In the debates over the validity of PPACA that occur outside the confines of litigation briefs, these broader themes of social meaning dominate. One main strategy of PPACA’s opponents has been to persuade legislatures in six states to adopt “health insurance freedom” laws that would prohibit any individual mandate, state or federal.¹¹⁵ In the 2010 election, voters in Arizona and Oklahoma amended their state constitutions to add the language of “health insurance freedom.”¹¹⁶ The primary purpose of these amendments is not the creation of new law. “Health insurance freedom” language adds nothing to disputes over whether the mandate exceeds the power of Congress. It is a makeweight for purposes of Tenth Amendment analysis. If the individual mandate is found to be within the scope of Article I powers, it will trump any and all conflicting state laws by virtue of the Supremacy Clause. The value of the “health insurance freedom” campaign

¹¹⁴ *Lochner v. New York*, 198 U.S. 45, 61 (1905), *abrogated by* *W. Coast Hotel Co. v. Parrish*, 300 U.S. 379 (1937).

¹¹⁵ See, e.g., GA. CODE ANN. § 31-1-11 (LEXIS through 2010 Reg. Sess. 2011); IDAHO CODE ANN. § 39-9003 (Supp. 2010); LA. REV. STAT. ANN. § 22:10186 (Supp. 15 2011); MO. ANN. STAT. § 1.330 (West, Westlaw through April 13, 2011); VA. CODE ANN. art. 4.1, § 38.2-3430.1:1 (Supp. 6A 2010). The American Legislative Exchange Council, an organization that “advocates limited government and free markets,” provided instruction to several states in developing these laws. Monica Davey, *Health Care Overhaul and Mandatory Coverage Stir States’ Rights Claims*, N.Y. TIMES, Sept. 29, 2009, at A25; see also Press Release, Am. Legislative Exch. Council, Freedom of Choice in Health Care Act, <http://www.alec.org/AM/Template.cfm?Section=FOCA&Template=/CM/HTMLDisplay.cfm&ContentID=15323> (last visited Mar. 15, 2011) (noting that forty-two states have utilized this model act in introducing or announcing health insurance freedom laws). The language of the Virginia statute is typical:

No resident of this Commonwealth, regardless of whether he has or is eligible for health insurance coverage under any policy or program provided by or through his employer, or a plan sponsored by the Commonwealth or the federal government, shall be required to obtain or maintain a policy of individual insurance coverage except as required by a court or the Department of Social Services where an individual is named a party in a judicial or administrative proceeding.

VA CODE ANN. § 38.2-3430.1:1.

¹¹⁶ See ARIZ. CONST. art. XXVII, § 2 (stating that no Arizonan shall be forced “to participate in any health care system” or be required to pay a fine for paying directly for health care); OKLA. CONST. art. II, § 37 (providing essentially the same guarantee).

to its proponents lies in the very process of enactment—in the opportunity created by the legislative debates and electoral campaigns to build public participation in the discourse of individual liberty as superior to collective obligation.¹¹⁷

III. CITIZENSHIP PRACTICES AND THE PATIENT PROTECTION AFFORDABLE CARE ACT

In this Part, I argue for using a concept of citizenship practices to understand the socio-legal relationship between individuals and social insurance programs. As I use it, the term “citizenship practices” incorporates the functional components of citizen-like activities, such as participation in governance, and also captures the ways in which the design of social welfare laws shapes individual and social understandings of identity and belonging. I describe some of the most important structural design questions that remain open for decision during the implementation phase of PPACA, with a focus on points that will enhance or curb the potential for citizen engagement in governance. I close this Part with commentary on possible future social meanings of PPACA.

A. *The Concept of “Citizenship Practices”*

Throughout this Article, I have sought to build on the usefulness of citizenship as a metaphor without becoming ensnared in its formal definition. The difficulties of navigating that tension lead me to propose the term “citizenship practices” as a better tool for signifying a multi-dimensional, nontechnical, and normative concept of citizenship, rather than stretching citizenship as a metaphor so far that the word becomes almost meaningless.

I intend “citizenship practices” to denote both concrete activities and the social meanings associated with citizenship. Specifically, I mean it to denote the discourses, institutions, and statutory programs

¹¹⁷ See, e.g., LAURA INGRAHAM, *THE OBAMA DIARIES* 119 (2010) (expressing the point of view that PPACA infringes on constitutional rights); BILL O'REILLY, *PINHEADS AND PATRIOTS: WHERE YOU STAND IN THE AGE OF OBAMA* 57-60 (2010) (describing PPACA and arguing that it passed only because of political maneuvering); MICHAEL SAVAGE, *TRICKLE UP POVERTY* 115-53 (2010) (discussing PPACA's shortcomings in language aimed at a lay audience); Sally C. Pipes, *Repeal the Individual Mandate of Obamacare*, HUMANEVENTS.COM (Aug. 12, 2010), <http://www.humanevents.com/article.php?id=38517> (describing the individual mandate as “an egregious assault on our economic liberty”); *The Rush Limbaugh Show: Battle over Obamacare Repeal Is Essentially a Debate About Liberty* (Premier Radio Networks Dec. 14, 2010), available at http://www.rushlimbaugh.com/home/daily/site_121410/content/01125113.guest.html (arguing that PPACA infringes on the American people's liberty by forcing them to buy health care).

that comprise a network of social structures. This network in turn gives birth to the constellation of rights, obligations, and belonging that we associate with citizenship. These structures exist within the state, the market, and contemporary civil society. "Citizenship practices" manifest in narrative, identities, and institutions, as well as laws.

I specifically intend the term to build on the concept of "policy feedback"—the ways that "policies, once enacted, restructure subsequent political processes"¹¹⁸—as well as on the idea of citizenship as metaphor. Theda Skocpol, a leading developer of the idea of policy feedback, has described such effects as not only those that could transform state administrative capacity but also those that can affect the identities, political goals, and capabilities of social groups.¹¹⁹ PPACA will surely fulfill both possibilities, but it is the latter set of effects that overlaps with citizenship practices, insofar as they help to frame narratives about who is responsible for what and why, and who has a legitimate expectation of participatory engagement in policymaking.

Policy and program design are key forces in structuring the ways in which individuals and social welfare systems interact. The particulars of such design will shape whether mechanisms exist that can force, enhance, or limit public participation in deliberation, as well as how successful such mechanisms will be. In turn, answers to those questions will foretell the extent to which interest groups will form and flourish around the needs of program constituents. From these roots, perceptions will arise about how, why, and for whom the programs operate.

B. *The Design of Exchanges Under PPACA*

In the health care arena, alternative modes of citizenship practices could be especially important. Voters elect officials who determine health policies, but it is usually not possible to unbundle health from other issues. Moreover, citizen engagement with respect to elections is low, as captured by Michael Walzer's description of citizens as "spectators who vote."¹²⁰ Exchange-level entities, on the other hand, could provide more localized opportunities for developing citizenship skills such as self-governance and leadership, as well as a venue in which smaller decisions may ultimately shape larger and more distant poli-

¹¹⁸ THEDA SKOCPOL, PROTECTING SOLDIERS AND MOTHERS: THE POLITICAL ORIGINS OF SOCIAL POLICY IN THE UNITED STATES 58 (1992).

¹¹⁹ *Id.*

¹²⁰ Michael Walzer, *The Civil Society Argument*, in THE CITIZENSHIP DEBATES 291, 300 (Gershon Shafir ed., 1998).

cymaking. Two critically important issues for the development of citizenship practices and policy feedback dynamics under PPACA will be whether the new institutions created pursuant to PPACA could also create potential sites for policy entrepreneurs seeking to maximize democratic input into health policy to intervene, and whether these institutions will facilitate an allegiance to norms of social insurance on the part of those who participate in them.

Section 1311 of PPACA requires states to establish "American Health Benefit Exchanges" by January 1, 2014.¹²¹ PPACA distinguishes between exchanges for individual purchasers of health insurance and exchanges for small businesses seeking to find coverage for their employees (the "Small Business Health Options Program"), and allows states to choose between creating two exchanges or one that will serve both markets.¹²² Alternatively, states may join with one another to create regional insurance exchanges,¹²³ offering consumers increased economies of scale and portability, or may opt into a federally run exchange.¹²⁴ In addition to creating a competitive marketplace for insurance and pooling risk for groups that traditionally have been hard to cover, the exchanges will also channel eligible individuals into Medicaid, CHIP, and other public programs.¹²⁵

PPACA provides initial funding for the exchanges,¹²⁶ but leaves states considerable discretion in structuring the design and implementation thereof, creating a fundamentally federalist system for procuring

¹²¹ PPACA § 1311, 42 U.S.C.A. § 18031(b) (West Supp. 1B 2010). If by January 1, 2013, the Secretary of Health and Human Services determines that a state has not taken the necessary steps toward establishing an exchange and will not have a functional exchange in place by 2014, the Secretary will establish and operate an exchange in that state. *Id.* § 1321(c), 42 U.S.C.A. § 18041(c).

¹²² *Id.* § 1311, 42 U.S.C.A. § 18031(b)(1)–(2).

¹²³ *Id.*, 42 U.S.C.A. § 18031(f)(1). New Mexico, for example, interprets the benefits of a regional exchange to include increased long-run efficiencies and expanded portability for residents. NEW MEXICO HUMAN SERVS. DEP'T, IMPLEMENTING FEDERAL HEALTH CARE REFORM—A ROADMAP FOR NEW MEXICO 26 (2010).

¹²⁴ See PPACA § 1321(c) (authorizing the U.S. Department of Health and Human Services to establish exchanges in noncompliant states after January 1, 2013).

¹²⁵ *Id.* § 1311, 42 U.S.C.A. § 18031(d)(4).

¹²⁶ *Id.*, 42 U.S.C.A. § 18031(a). The Health Insurance Exchange Planning grant provides states with funding for economic modeling, actuarial analyses, data collection, and identification of necessary resources such as information technology to create an exchange. *Id.*, 42 U.S.C.A. § 18031(a)(1)–(3). Forty-eight states and the District of Columbia received the first round of grants in September 2010. OFFICE OF CONSUMER INFO. & INS. OVERSIGHT, U.S. DEP'T OF HEALTH & HUMAN SERVS., INITIAL GUIDANCE TO STATES ON EXCHANGES (2010), available at http://www.healthcare.gov/center/regulations/guidance_to_states_on_exchanges.html.

health insurance for individuals and small businesses. It is likely that most states will exercise the opportunity to create their own exchanges in order to streamline coordination with related state programs such as Medicaid and to tailor the exchange to their population's needs.¹²⁷

With little statutory guidance on exchange functions, structure, and governance, states have a great deal of discretion to exercise in a short window of time.¹²⁸ The most likely models exist in Massachusetts, Utah, and states that, like California, were among the earliest to create exchanges.¹²⁹ In 2006, when Massachusetts imposed its own mandate on state residents, it created the Commonwealth Health Insurance Connector to help individuals purchase affordable coverage.¹³⁰ The Massachusetts Connector provided a template for the exchange system established in PPACA.¹³¹ Utah created a similar exchange in 2009,¹³² and California enacted legislation in 2010 creating the California Health Benefit Exchange.¹³³ These three models are likely to guide other states as they make decisions regarding important governance issues in the process of creating PPACA compliant exchanges. Two such issues are whether an exchange will act as a clearinghouse or as an active purchaser of plans, and whether the exchange will be housed in a government agency or a nonprofit entity.

¹²⁷ For example, New Mexico's strategic plan for health care reform has identified these reasons as sufficient to justify the expense of establishing its own exchange. NEW MEXICO HUMAN SERVS. DEP'T, *supra* note 123, at 25-26; *see also* ROBERT CAREY, STATE COVERAGE INITIATIVES, HEALTH INSURANCE EXCHANGES: KEY ISSUES FOR STATE IMPLEMENTATION 2-3 (2010), *available at* <http://www.rwjf.org/files/research/70388.pdf> (describing why states will likely prefer to create their own exchanges, rather than be subject to a federally run exchange). In addition, the New Mexico Human Services Department has noted that "ambitious federal timelines" may prohibit development of a regional exchange. NEW MEXICO HUMAN SERVS. DEP'T, *supra* note 123, at 26-27.

¹²⁸ *See* JOST, *supra* note 97, at 5 (noting that states face a "daunting list of tasks").

¹²⁹ *See* Rachel Brand, *Facing the Future: Setting up Health Insurance Exchanges is One of the Big, Early Tasks for Lawmakers*, STATE LEGISLATURES, at 22, 24-26, Oct.-Nov. 2010 (discussing early state efforts at exchange creation).

¹³⁰ MASS. ANN. LAWS ch. 176Q, § 3 (LexisNexis Supp. 2009).

¹³¹ *See* STAFF OF SENATE FIN. COMM., 111TH CONG., DESCRIPTION OF POLICY OPTIONS: EXPANDING HEALTH CARE COVERAGE: PROPOSALS TO PROVIDE AFFORDABLE COVERAGE TO ALL AMERICANS 4 (2009) ("[T]he Health Insurance Exchange concept is similar in some ways to the Massachusetts Connector . . .").

¹³² UTAH CODE ANN. § 31A-2-218(3) (LexisNexis Supp. 2010).

¹³³ California Patient Protection and Affordable Care Act, ch. 655, sec. 3, § 15438(s)(1), 2010 Cal. Stat. 3553, 3556 (to be codified at CAL. GOV'T CODE § 15438).

1. Regulation

States must determine how much oversight they will exercise over health insurance plans offered through their exchanges. PPACA restricts entry to the exchange to those plans whose availability in an exchange serves the “interests of qualified individuals and qualified employers,”¹³⁴ those that offer at least silver and gold benefit tiers, and those that meet additional criteria to be established by the Secretary.¹³⁵ States may opt to impose additional participation requirements on plans, allowing the exchange to serve as a gatekeeper to maximize quality and minimize cost.¹³⁶

Some states may follow the Utah Health Exchange model, and provide a “clearinghouse” of health insurance plans that meet the federal minimum standards.¹³⁷ This model, which could be analogized to various online commercial websites, would allow consumers the greatest number of options, but may fall short of providing them with the best value for their health care dollars by not imposing further requirements.

States that choose to impose greater regulation on the plans offered through the exchange could adopt what has been termed a “selective contracting agent” model.¹³⁸ Under such a model, the exchange would evaluate insurance plans from different corners and offer only selected plans.¹³⁹ The Massachusetts Connector operates this way,¹⁴⁰ and has thus far granted entry to nine health plans. California’s exchange will also selectively contract with plans to create a market of “optimal combination of choice, value, quality, and ser-

¹³⁴ PPACA § 1311, 42 U.S.C.A. § 18031(e)(1) (West Supp. 1B 2010).

¹³⁵ *Id.* § 1301, 42 U.S.C.A. § 18021(a)(1)(c)(ii).

¹³⁶ Initial guidance from the Department of Health and Human Services endorses the variety of models, leaving the choice up to states. See OFFICE OF CONSUMER INFO. & INS. OVERSIGHT, *supra* note 126 (“States have a range of options for how the Exchange operates from an ‘active purchaser’ model . . . to an ‘open marketplace’ model . . .”).

¹³⁷ Utah’s exchange model has been described as functioning as a “market organizer.” See ROBERT CAREY, STATE COVERAGE INITIATIVES, PREPARING FOR HEALTH REFORM: THE ROLE OF THE HEALTH INSURANCE EXCHANGE 4-5 (2010), available at <http://www.rwjf.org/files/research/57093.pdf> (describing how the exchange acts as a source of information about available plans, provides structure to the market, and serves as a broker by handling billing and collection).

¹³⁸ CAREY, *supra* note 127, at 12.

¹³⁹ *Id.*

¹⁴⁰ See MASS. ANN. LAWS ch. 176Q, § 3(a)(3) (LexisNexis Supp. 2009) (noting that the Connector’s purpose is to establish procedures for selecting and certifying plans to be offered).

vice,”¹⁴¹ limiting participation to those plans offering five tiers of coverage (ranging from catastrophic-only to platinum coverage) both on and off of the exchange.¹⁴² Other states struggling with rising health care costs may find this selective contracting option attractive, as it will allow regulators to best control premium growth.¹⁴³

Finally, states could take more initiative in governing which plans will be offered through their exchanges by acting as “active purchasers” of the health insurance plans offered.¹⁴⁴ Under such a structure, the state exchanges would be able to operate as large employers already do, negotiating prices for a large risk pool and offering access only to the plans with the best bids.

One policy analyst has noted that these latter two models allow the exchanges to fulfill their full potential as “critical forces in the market to keep prices down and generate better quality care for consumers, employers and taxpayers.”¹⁴⁵ Though these models envision a greater role, and thus greater effort, by the states, the models likely will provide consumers with a more streamlined way to purchase health insurance that will be valuable to them and responsive to their needs. Regardless of the model chosen, after allowing a plan to enter the exchange, a state must regularly account for premium increases in determining its continued viability for the exchange, thereby helping to control price.¹⁴⁶

¹⁴¹ CAL. HEALTH CARE FOUND., CALIFORNIA’S INSURANCE EXCHANGE: EXPERTS TACKLE THE BIG QUESTIONS 6-7 (2010) (quoting Sumi Sousa, Special Assistant to Assembly Speaker John A. Perez).

¹⁴² See *id.* at 11 (noting that the California exchange requirements will exceed federal requirements).

¹⁴³ New Mexico has identified cost control as a reason to consider limiting exchange participation to plans restricting premium growth or offering other cost containing measures to keep premiums low. NEW MEXICO HUMAN SERVS. DEP’T, *supra* note 127, at 25-26.

¹⁴⁴ See CAREY, *supra* note 137, at 5 (listing California’s PacAdvantage and the Texas Insurance Purchasing Alliance as examples of the active purchaser models).

¹⁴⁵ NAIC Exchange Subgroup Public Hearing (July 22, 2010) (statement of Sabrina Corlette, Georgetown University Health Policy Institute) (on file with author).

¹⁴⁶ See PPACA §§ 1311, 10104(f)(1), 42 U.S.C.A. § 18031(e)(2) (West Supp. 1B 2010) (“The Exchange shall require health plans seeking certification . . . to submit a justification for any premium increase prior to implementation of the increase The Exchange shall take this information . . . into consideration when determining whether to make such health plan available through the Exchange.”).

2. Public or Private Forms

Second, the law requires each state to create an exchange as either a “governmental agency or nonprofit entity . . . established by a State,”¹⁴⁷ meaning that a state that does not utilize the federally run exchange must house an exchange within the government or create a new nonprofit.¹⁴⁸ Indeed some states have utilized one or the other of these forms in order to reach a decision as to the form of the permanent structure.¹⁴⁹

Efficiency considerations¹⁵⁰ may be in tension with other concerns. A publicly run exchange would be directly linked with the state’s administration, facilitating communication with related government bodies (including the state Medicaid office, insurance department, and consumer protection agency).¹⁵¹ State-operated exchanges will also likely offer greater transparency, a factor that California considered in deciding to create an independent government entity.¹⁵² However, despite ease of communications with related entities, state bureaucracy and political considerations may slow or complicate decisionmaking, hiring, and contracting.¹⁵³ Creating an independent or quasi-governmental public agency—or a nonprofit organization—could alleviate some of these concerns by uncoupling these functions from politicians but would reduce the efficiencies gained by having direct contact with state agencies.¹⁵⁴

¹⁴⁷ *Id.* § 1311, 42 U.S.C.A. § 18031(d)(1).

¹⁴⁸ Because state exchanges are required to be self-sustaining by 2015, states are expected to prioritize issues of efficiency. *Id.*, 42 U.S.C.A. § 18031(d)(5).

¹⁴⁹ For example, Iowa created the Iowa Legislative Health Care Coverage Commission in 2009 to determine, among other things, where to house an exchange that shall be operational by July 1, 2011. Act of May 19, 2009, ch. 118, § 1.1.a(f), 2009 Iowa Acts 391, 392. Colorado has instead charged its Division of Insurance with identifying the necessary changes to Colorado law that PPACA will require. *See* LOREZ MEINHOLD, OFFICE OF THE GOVERNOR, IMPLEMENTING HEALTH CARE REFORM: A ROADMAP FOR COLORADO 13 (2010) (noting that the Colorado Division of Finance is inventorying PPACA and state insurance law).

¹⁵⁰ *See* PPACA § 1311, 42 U.S.C. § 18031(d)(5) (imposing limitations on allocation of funds, including restrictions on wasteful expenditures).

¹⁵¹ *See, e.g.*, AMERICAN HEALTH BENEFIT EXCHANGE MODEL ACT, § 4(A) drafting note (Nat’l Ass’n of Ins. Comm’rs, Draft 2010) (addressing benefits of locating insurance exchanges in a state agency as opposed to other models).

¹⁵² *See* CAL. HEALTH CARE FOUND., *supra* note 141, at 9 (“[California] decided on a government option principally because government ‘has to conduct its business in the public.’” (quoting Jennifer Kent, Deputy Sec’y for Legislation, Office of the Governor)).

¹⁵³ *Cf. id.* (discussing the need to make the exchange’s structure “nimble”).

¹⁵⁴ *See* FAMILIES USA, IMPLEMENTING HEALTH INSURANCE EXCHANGES: OPTIONS FOR GOVERNANCE AND OVERSIGHT 5-6 (2011), available at <http://familiesusa2.org/assets/>

Additionally, state-run exchanges may pose bigger conflict-of-interest problems.¹⁵⁵ For example, Connecticut recently created Sustinet, a state-run health plan that will be offered on Connecticut's exchange if it is certified as a qualified plan.¹⁵⁶ Sustinet's Board of Directors has noted that governance of the state-run plan and the exchange must be entirely distinct to avoid a conflict of interest and has recommended that Connecticut either opt into the federal exchange or place Sustinet in the hands of a quasi-governmental agency that is removed from the state government.¹⁵⁷

Finally, choosing between state and privately run exchanges will implicate basic capacity concerns. The selected body must have the facility to govern the exchange, including performing the minimum set of regulatory functions PPACA sets forth (e.g., certifying plans to participate, making limited-eligibility determinations, and monitoring benefits and plan offerings) along with any additional requirements state law imposes. States opting to place the exchange within the state government will likely create new entities, as extant bodies are ill-suited to perform governance functions,¹⁵⁸ although some states may opt to place an exchange within the state governor's office, as Utah did.¹⁵⁹ Other states—such as Massachusetts, California, and Connecticut—have or are planning to create a new state agency, and will appoint a small governing board (e.g., five to ten people) that includes individuals representing the expertise the exchanges will demand (such as

pdfs/health-reform/Exchanges-Governance-and-Oversight.pdf (discussing the advantages and disadvantages of state "quasi-governmental" agencies to hosting the exchanges).

¹⁵⁵ See Jon Kingsdale & John Bertko, *Insurance Exchanges Under Health Reform: Six Design Issues for the States*, 29 HEALTH AFF. 1158, 1159 (2010) (raising concerns about unfair discrimination among carriers).

¹⁵⁶ Sustinet coverage is available immediately to Medicaid and HUSKY beneficiaries and state employees or retirees, and to small or not-for-profit businesses and municipalities as of July 1, 2012. NANCY WYMAN & KEVIN LEMBO, SUSTINET HEALTH P'SHIP BD. OF DIRS., IMPLEMENTING SUSTINET FOLLOWING FEDERAL ENACTMENT OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT OF 2010: A PRELIMINARY REPORT TO THE CONNECTICUT GENERAL ASSEMBLY 1 (2010).

¹⁵⁷ *Id.*

¹⁵⁸ See JOST, *supra* note 97, at 2-6 (noting that Medicaid agencies may be incompetent to perform exchange regulatory functions, but that consumer protection agencies in some states may be appropriate bodies for the exchanges); see also CAREY, *supra* note 127, at 6 (noting that "natural homes" for an exchange may be found in state insurance departments, Medicaid agencies, and administrators of state employee health benefits, but that all three lack specialized expertise in administering an exchange).

¹⁵⁹ Utah housed its exchange within the Governor's Office of Economic Development, under a new branch entitled the Office of Consumer Health Services. UTAH CODE ANN. 63M-1-2504 (LexisNexis Supp. 2010).

economists, actuaries, plan benefit specialists, and health policy experts) along with representatives from interested parties (such as businesses, insurers, health care providers, and consumers).¹⁶⁰ In addition, states must exercise caution to avoid creating conflicts of interest.¹⁶¹ Even if a new entity is created to govern an exchange, close interaction with related state agencies will be critical. For example, a governor's office will likely play a central role in appointing some or all of the board members.¹⁶² Although exchanges will not be required to conduct eligibility determinations with respect to tax subsidies or exemptions,¹⁶³ they will need close contact with state Medicaid and insurance agencies to facilitate proper referrals of those eligible for public coverage.

3. Information Requirements and Consumer Participation

Two key goals of PPACA's exchanges are to create greater information disclosure and to foster public participation in the health insurance sector. The exchanges expand consumer access to plan in-

¹⁶⁰ For example, Connecticut's Health Care Reform Advisory Board has recommended that the state create a board chaired by the Secretary of the Office of Policy and Management. The board's composition should include an actuary, a plan benefit specialist, a health care economist, the Commissioners of Social Services, Public Health, and Insurance, and the State Comptroller, as well as representatives from small and large businesses, insurers, providers, and consumers. CONN. HEALTH CARE REFORM ADVISORY BD., FINAL REPORT TO GOVERNOR RELL AND THE GENERAL ASSEMBLY 10 (2010). Massachusetts's Connector is governed by a board composed of four public officers as well as six appointed members (three appointed by the office of the attorney general and three by the governor's office). MASS. ANN. LAWS ch. 176Q, § 2 (Lexis-Nexis Supp. 2010). The board governing California's exchange will include two members appointed by the governor, one each appointed by the state senate and house, and one appointed by the Secretary of Health and Human Services. Act of Sept. 30, 2010, ch. 659, sec. 2, § 10500(a) 2010 Cal. Stat. 3598, 3599 (to be codified at CAL. GOV'T CODE § 10500). For a discussion of the structure of governing boards of exchanges, see JOST, *supra* note 97, at 6-7.

¹⁶¹ States will likely have to prohibit representatives from the health care and insurance industries from board participation. For example, California's law prohibits a board member from seeking employment with an insurer, agent, broker, or health care provider within one year of service, and bars any compensation during service. Sec. 2, § 10500(f)(2), 2010 Cal. Stat. at 3599. For a more in-depth discussion, see JOST, *supra* note 97, at 6-7 (discussing how to structure agency boards in order to prevent conflicts of interest).

¹⁶² See JOST, *supra* note 97, at 7 (noting that the most common state board structure will require the governor's office to appoint board members subject to approval by the legislature).

¹⁶³ PPACA requires the Treasury to make subsidy payments directly to plans, meaning that a state exchange may decline any involvement in the eligibility process. Cf. CAL. HEALTH CARE FOUND., *supra* note 141, at 5 (noting that this provision is different from the payment structure in Massachusetts).

formation and create avenues for public involvement in the decision-making process. The specific aims are to facilitate easy plan comparison, to maximize transparency, and to boost competition. Moreover, this “two-way street” will cultivate consumer participation in the structuring of exchanges and regulations, thereby augmenting public acceptance of a changing health care market.

a. *Providing Consumer Information*

PPACA requires exchanges to facilitate easy comparisons of plan benefits, costs, and policies, seeking to maximize competition among participating plans. More specifically, the law requires states to provide, at a minimum, plain language summary information and quality ratings.¹⁶⁴ PPACA also requires states to engage hard-to-reach populations.¹⁶⁵ For assistance in providing this information, states may apply for grants to expand or create offices of health insurance consumer assistance or ombudsman programs.¹⁶⁶

The plain language summaries of plan benefits,¹⁶⁷ as well as quality ratings,¹⁶⁸ will supplement information already available on a federally created website providing plan information.¹⁶⁹ This information must incorporate data on provider accessibility, cost sharing, health outcomes, readmission rates, safety and error reduction programs, medical-loss ratios, claims payment and denial policies, enrollment patterns, and wellness plans,¹⁷⁰ and be available via website as well as

¹⁶⁴ PPACA § 10104(f)(2), 42 U.S.C.A. § 18031(e)(3)(B) (West Supp. 1B 2010).

¹⁶⁵ *Id.* § 1311, 42 U.S.C.A. § 18031(d)(6)(e).

¹⁶⁶ *Id.* sec. 1002, § 2793, 42 U.S.C.A. § 300gg-93 (West Supp. 1A 2010). In 2011, twenty-nine million dollars of grant money is available for the development or expansion of consumer assistance programs. Grants will be awarded by the Department of Health and Human Services’s Office of Consumer Information and Insurance Oversight (OCIO). OFFICE OF CONSUMER INFO. & INS. OVERSIGHT, DEP’T OF HEALTH & HUMAN SERVS., CFDA NO. 93,519, AFFORDABLE CARE ACT—CONSUMER ASSISTANCE PROGRAM GRANTS INITIAL ANNOUNCEMENT: INVITATION TO APPLY FOR FY 2010, at 4 (2010).

¹⁶⁷ PPACA § 10104(f)(2) (West Supp. 1B 2010). The format for plan summaries will be designed by the Secretary based on input from the National Association of Insurance Commissioners. *Id.* § 1311, 42 U.S.C.A. § 18031(c)(1)(F).

¹⁶⁸ Ratings must be available for each tier of coverage, based on the relative quality and price of each participating plan, as well as beneficiary satisfaction scores for plans serving over 500 individuals. *Id.* § 1311, 42 U.S.C.A. § 18031(c)(3)–(4).

¹⁶⁹ PPACA requires the Department of Health and Human Services to create a website helping consumers to identify coverage options by July 1, 2010. *Id.* § 1103, 42 U.S.C.A. § 18003.

¹⁷⁰ *See, e.g., id.* § 1001, 42 U.S.C.A. § 300gg-17 (West Supp. 1A 2010) (requiring health insurance providers to cover wellness programs). Additionally, plans participat-

through a toll-free hotline.¹⁷¹ States will have to determine whether to make summary information binding on insurers, which may prevent plans from attracting consumers based on misrepresentations.¹⁷² Although not required, additional user-friendly features will likely further stimulate increased competition. For example, the Massachusetts Connector provides consumers with a side-by-side comparison of plans at a given coverage level based on the user's age, household size, and zip code.¹⁷³ California's law authorizes the exchange board to require each participating plan to make an electronic directory of network providers available to users.¹⁷⁴

In addition to providing easily accessible information, PPACA requires states to take steps to reach out to those least likely to use the exchange. While employed individuals will receive notice of an available exchange from an employer,¹⁷⁵ the state must target hard-to-reach individuals in need of coverage, thereby increasing the efficacy of the mandate. PPACA also requires states to award grants to entities serving as "navigators."¹⁷⁶ These entities must perform outreach services, including public education campaigns, distribution of information, and referrals to consumer assistance offices.¹⁷⁷ Some states have already created navigator-type entities for public coverage options but

ing on the exchanges must report data on in- and out-of-network provider availability and cost sharing to the Department of Health and Human Services. *See id.* § 1311, 42 U.S.C.A. § 18003(c)(1)(B) (West Supp. 1B 2010) (detailing requirements for plan certification); *id.* § 1311, 42 U.S.C.A. § 18003(e)(2)–(3) (explaining that an exchange may certify a health plan if it meets certification guidelines). For a discussion of reporting requirements, see JOST, *supra* note 97, at 31–32.

¹⁷¹ PPACA § 1311, 42 U.S.C.A. § 18031(d)(4).

¹⁷² While PPACA requires that a plan summary must "accurately describe" the benefits and coverage a plan provides "so that consumers may compare health insurance coverage and understand the terms of coverage (or exception to such coverage)," it also requires that the summary direct the consumer to the plan itself to determine contractual details. *Id.* sec. 1001, §§ 2715(a), (b)(3), 42 U.S.C.A. § 300gg-15 (West Supp. 1A 2010); *see also* JOST, *supra* note 97, at 32–34 (discussing the "accurately describe" requirement and arguing that these descriptions should be legally binding).

¹⁷³ *See Health Connector*, MASSGOV.COM, <https://www.mahealthconnector.org/portal/site/connector> (last visited Mar. 15, 2011).

¹⁷⁴ California Patient Protection and Affordable Care Act, ch. 655, sec. 8, § 100504(a)(9), 2010 Cal. Stat. 3553, 3563 (to be codified at CAL. GOV'T CODE § 100504).

¹⁷⁵ PPACA requires employers to provide written notice to employees regarding the existence of an exchange and an employee's potential eligibility for a premium assistance tax credit and/or cost sharing reduction, as well as the potential loss of employer contribution to an employer-sponsored plan if the employee purchases coverage through the exchange. PPACA sec. 1512, § 18B, 29 U.S.C.A. § 218B.

¹⁷⁶ *Id.* § 1311, 42 U.S.C.A. § 18031(i) (West Supp. 1B 2010).

¹⁷⁷ *Id.*

will have to create additional programs to target individuals likely to purchase coverage on the exchange. For example, in New York, community-based organizations, consumer assistance programs, and facilitated enrollers conduct outreach to assist low-income individuals in accessing public coverage; New York will have to create navigators to provide information regarding the new exchanges as well.¹⁷⁸

b. *Seeking Consumer Input*

The inclusion of public participation in the implementation and functioning of the exchanges will be another component of establishing effective exchanges that are responsive to consumer needs.¹⁷⁹ Citizen input will create a two-way flow of plan information, potentially facilitating a dialogue about the efficacy of this revised health care market. PPACA requires that states engage consumers during implementation of the exchanges and that they seek continued input regarding plan quality.

To do this, PPACA mandates that states consult with diverse stakeholders in establishing exchanges, including health care consumers enrolled in qualified plans.¹⁸⁰ Colorado has taken the lead in engaging the public, holding weekly “office hours” with the director of health-reform implementation and organizing 150 outreach activities—including forums, conferences, and press conferences—since April 2010.¹⁸¹ Other states have focused their efforts to engage stakeholders on soliciting the opinions of varying interest groups by creating diverse advisory boards, rather than opening the floor to the greater public.¹⁸² Whether the latter approach will constitute adequate “stakeholder involvement” remains to be seen—to date, interim guidance issued by the Office of Consumer Information and Insurance Oversight (OCIO) has been limited. OCIO’s “Initial Guidance

¹⁷⁸ See N.Y. STATE HEALTH FOUND., IMPLEMENTING FEDERAL HEALTH CARE REFORM: A ROADMAP FOR NEW YORK STATE 32 (2010) (describing the duties of navigators and qualifications for eligibility to serve as a navigator in the state).

¹⁷⁹ Including greater public participation in health plans themselves is also a component of PPACA. The law includes funding for the establishment of the Consumer Operated and Oriented Plan (“CO-OP”) program, which will both increase competition and provide new consumer-directed options to the health insurance market. PPACA § 1322, 42 U.S.C.A. § 18042.

¹⁸⁰ *Id.* § 1311, 42 U.S.C.A. § 18031(d)(6).

¹⁸¹ See MEINHOLD, *supra* note 149, at 26 (describing Colorado’s outreach activities).

¹⁸² See *Getting Organized—How States Are Preparing to Implement National Health Reform*, STATES IN ACTION (The Commonwealth Fund, New York, N.Y.), July–Aug. 2010, at 10–12 (describing outreach efforts in Pennsylvania and Virginia).

to States on Exchanges” mentions the importance of public involvement in setting up the exchanges, stating that “[s]uccessful exchanges will work closely with consumer advocates,” among other stakeholders.¹⁸³ Further regulatory guidance on the types of stakeholders to involve, the degree of involvement, or the responsiveness of the exchange to public comment has not been provided. Nonetheless, incorporating consumer input may prove beneficial even if not a regulatory obligation. Indeed, even without this mandate, public input may prove to be a necessary element of meeting the duty to ensure that certified plans are “in the interests of qualified individuals and qualified employers.”¹⁸⁴

In addition to their role in giving input on the establishment of the exchanges themselves, citizens will also provide feedback on the health insurance plans offered through the exchanges. Section 1311(c) of PPACA is the primary vehicle for the transmission of information about health insurance plans offered through the exchanges. As discussed above, plan ratings will be based in part on an “enrollee satisfaction survey system” that § 1311(c)(4) requires the Secretary to establish.¹⁸⁵ This survey system, modeled after the system in place for the Federal Employee Health Benefit Program,¹⁸⁶ and, similar to consumer review tools that have become ubiquitous in online markets for other products,¹⁸⁷ provides an opportunity for consumers to comment on their satisfaction with their health plans. These reviews will help structure the landscape of plans that are offered through the exchanges. The enrollee-satisfaction component is intended to “make the proposed health care exchange easier to navigate while also providing consumers an effective way to hold their insurance company accountable.”¹⁸⁸

¹⁸³ OFFICE OF CONSUMER INFO. & INS. OVERSIGHT, *supra* note 126.

¹⁸⁴ PPACA § 1311, 42 U.S.C.A. § 18031(c)(1).

¹⁸⁵ *Id.* § 1311, 42 U.S.C.A. § 18031(c)(4).

¹⁸⁶ Press Release, Sen. Mark Pryor, Pryor Adds Consumer-Friendly Tool to Simplify Health Care Choices, Hold Insurance Companies Accountable (Dec. 7, 2009), *available at* <http://pryor.senate.gov/newsroom/details.cfm?id=320497&>.

¹⁸⁷ See Ezra Klein, *Mark Pryor Makes the Health Insurance Exchanges a Bit More Like Amazon.com*, WASH. POST BLOG (Dec. 7, 2009, 4:37 PM), http://voices.washingtonpost.com/ezra-klein/2009/12/mark_pryor_makes_the_health_in.html (comparing the survey system to consumer reviews prevalent on online shopping sites like Amazon.com).

¹⁸⁸ Press Release, *supra* note 186.

4. Summary

The characteristics described in this Part create only the potential for meaningful citizen engagement. System design will be critical in determining whether the capacity for effective citizenship practices is actually enhanced under PPACA.¹⁸⁹ Its construction as a private market-based social insurance system with multiple risk pools, for example, positions it differently than Social Security. Campbell found that the uniformity of rules in Social Security signals that each person's participation is equally legitimate, which in turn produces more such activity.¹⁹⁰ PPACA is neither entirely uniform the way Social Security is nor is it a fully means-tested program like Medicaid.¹⁹¹

There is ample authority in PPACA for policymaking that would enhance participatory governance, especially at the exchange level. Just as the impact of Social Security was unknown at the time of its enactment, the full potential for development of citizenship practices under PPACA is currently unknown. Much will depend on state-level initiatives and whether federal officials permit or facilitate such initiatives.

C. *Social Meanings of PPACA*

Although one cannot be sure today of how significant the opportunities for the exercise of participation rights may become under PPACA, the essential functions and components of social insurance systems—which mimic citizenship norms—exist in PPACA's structure.

First, PPACA creates a system of multiple mutual benefits among individual participants. The benefits to each person are unpredictable and contingent: Person A may reap only modest value from years of investment through the payment of premiums, but she is virtually certain to realize some significant benefits over time. In such a system, formal constraints are necessary to prevent free-rider problems. Other mutual financial benefits include protection against wasteful use of public funds to compensate providers for treatments furnished

¹⁸⁹ See CAMPBELL, *supra* note 73 at 125-37 (describing survey results finding that participation rates differed across different benefit programs); COHEN, *supra* note 48, at 23-37, 66-69, 345-357 (describing the impact that consumers can have and the participation and citizen activity of consumer movements throughout the twentieth century).

¹⁹⁰ CAMPBELL, *supra* note 73, at 138.

¹⁹¹ Campbell attributes lower levels of political engagement by participants in means-tested programs in part to the contrast between a professionalized Social Security bureaucracy that applies clear standards to an entire population and programs for the needy characterized by stigma, red tape, and complex eligibility criteria. *Id.* at 129-32.

to the uninsured and the reduction of transaction costs in providing all medical treatments.

There is also mutual benefit in the spillover of positive externalities that accrue to population health and thus to participants collectively. Public health studies have shown that insurance status is positively correlated with improved health outcomes for individuals.¹⁹² Economic analyses suggest that increasing health insurance coverage in the United States would result in large national-level socioeconomic gains.¹⁹³ In addition, recent outbreaks of infectious diseases, often on a global scale, indicate that removing barriers to treatment for those exposed to such diseases is an important aspect of the defense of a community.¹⁹⁴

Second, PPACA creates reciprocal obligations. The system's provision of health insurance will provide protection to the individual against possibly devastating financial risk in exchange for the relatively minor obligation to purchase it. Government is in effect insuring the insurers. On a more philosophical level, the new law will strengthen social norms of solidarity and responsibility and extend a deeper consciousness of these norms to public discourse related to the health care system.

In sum, PPACA extends the functional aspects of citizenship to the American health care system for the first time. Rather than privatizing health care, as has recently occurred in nations that adopted a much more public system after World War II, the United States has approached a social insurance system from essentially the opposite direction. PPACA retains a private system of market exchange, but "publicizes" it by importing a limited, but significant, set of public-sector characteristics.

What remains missing is a coherent, broadly shared public narrative about the meaning of PPACA. The frustration and delay of that component of the law's potential has been the primary achievement

¹⁹² See, e.g., Peter Franks et al., *Health Insurance and Mortality: Evidence from a National Cohort*, 270 JAMA 737, 740 (1993) (finding that insurance has a similar effect on mortality as socioeconomic status, education, and self-rated health).

¹⁹³ See James A. Thornton & Jennifer L. Rice, *Does Extending Health Insurance Coverage to the Uninsured Improve Population Health Outcomes?*, 6 APPLIED HEALTH ECON. & HEALTH POL'Y 217, 228 (2008) ("[T]here may be large social economic benefits and net benefits from extending health insurance coverage to the uninsured.").

¹⁹⁴ See, e.g., Matthew K. Wynia & Lawrence Gostin, *The Bioterrorist Threat and Access to Health Care*, 296 SCIENCE 1613, 1613 (2002) (noting that uninsured Americans who could not access evaluation and care for infectious disease pose a national security threat in the event of a bioterrorism attack).

so far of the campaign of constitutional challenges against it. Assuming that the Supreme Court eventually upholds PPACA, the opening of the exchanges in 2014 may create a fresh opportunity for social-meaning entrepreneurs to create the foundations for health care system citizenship practices.

CONCLUSION

Governance processes—and not simply the rules that establish program content and eligibility—have a profound effect on whether the broader impact of a reform will be expressive of democratic values. A social welfare reform of the magnitude of PPACA will almost certainly generate new citizenship practices vis-à-vis the health system, although the direction of that change is not yet clear. The two most important aspects of new citizenship practices that could develop under PPACA are its potential, over time, to instantiate a new reciprocal covenant of mutual security, and its potential to enhance participatory self-governance.

It will be years before we know whether the new health reform law will alter the social meaning of membership in the American community, and if so, how. PPACA represents the first attempt in U.S. history to provide (almost) universal health insurance, yet it does so in a way that preserves a fragmented market and perpetuates structural inequalities in access to coverage. As this Article goes to press, there is no assurance that the new law—and especially the individual mandate—will even survive judicial scrutiny.¹⁹⁵

Lacking a crystal ball and in recognition of two earlier, bitterly fought efforts to secure new public goods, let me close by borrowing from both Benjamin Franklin¹⁹⁶ and the health reform proposal advanced by President Clinton¹⁹⁷: What have we created by enacting PPACA? It's a health security system, if you can keep it.

¹⁹⁵ See *supra* note 98 (citing cases challenging PPACA).

¹⁹⁶ Franklin engaged in the following exchange after the conclusion of the Constitutional Convention: “Well, Doctor, what have we got—a Republic or a Monarchy?” ‘A Republic, if you can keep it.’ RESPECTFULLY QUOTED: A DICTIONARY OF QUOTATIONS FROM THE LIBRARY OF CONGRESS 299 (Suzy Platt ed., 1992).

¹⁹⁷ See American Health Security Act of 1993, H.R. 1200, 103d Cong. § 101 (1993) (“establish[ing] . . . a State-Based American Health *Security* Program” (emphasis added)).